Christian views of euthanasia: a comparison of Russian and western perspectives

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ABSTRACT

The following research aims at unfolding an authentic Christian attitude to euthanasia by means of a comparative analysis of Christian bioethical thinking and practice in Russia and in the West. It seeks to establish what is euthanasia, whether it is incompatible with Christianity and, if so, what is the alternative.

The first chapter explores the meaning of 'euthanasia', comparing and rethinking a number of definitions from the existing multitude. Through the psychological thicket of slogans such as "mercy killing", "personal autonomy" and "death with dignity" the core characteristic of euthanasia – deadly intention – is hardly ever seen.

With some notable exceptions with regard to self-defence, just war, or capital punishment, in Christianity intending to kill has always been regarded as a grave sin of breaking the sixth commandment. The second chapter shows how Western Christian bioethics has gone from the ethics of Paul Ramsey to the ethics of Tristram Engelhardt, from balancing between justifying certain forms of intentional killing while condemning others to purifying one's heart and cultivating one's soul in order to prevent the formation of an intention to kill.

The third chapter is dedicated to the development of Christian bioethics in Russia. In a country with over a millennium of Orthodox tradition there is an exceptional opportunity for the bioethical framework of Engelhardt to settle in naturally.

The fourth chapter presents a number of well-publicized medical situations in Britain where choices between life and death were exercised. The analysis based on the material of the previous chapters shows most of them to be clear cases of euthanasia, while others have a recognizable potential to be described as such.

The history and an ongoing story of the modern hospice movement – a living alternative to euthanasia – are the focus of the fifth and last chapter of this dissertation. Its core ability – to live with suffering – sustains the opposition to euthanasia and is essentially a Christian virtue.

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This thesis is the product of my own work, and the work of others has been properly acknowledged throughout.

In loving memory of my grandmothers,

Evgenia Lastochkina and **Maria Epikhina**

and

to the late **Bishop Donald Nestor**

I dedicate this work.

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LIST OF ABBREVIATIONS

BDS	T. I. Grekova, 'Belief and Disbelief of Scholars'
BMA	British Medical Association
BMD	*Black's Medical Dictionary*
BMJ	*British Medical Journal*
BMLR	*Butterworths Medico-Legal Reports*
BRPP	B.G. Yudin (ed.), *Bioethics: Rules, Principles and Problems*
CA	Irina Siluyanova, '*Convention on Human Rights and Biomedicine* of the Council of Europe and the *Foundations of the Social Concept of the Russian Orthodox Church:* Comparative Analysis'
CAAS	K. Foley and H. Hendin (eds.), *The Case Against Assisted Suicide: For the Right to End-of-Life Care*
CS	Shirley Du Boulay, *Cicely Saunders: The Founder of the Modern Hospice Movement*
DPP	Director of Public Prosecutions
E&M	*Ethics and Medicine*
EB	*Euthanasia Booklet*
EC	Irina Siluyanova, *Ethics of Cure: Modern Medicine and Orthodoxy*
EE	John Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*
EEL	Paul Ramsey, *Ethics at the Edges of Life*
EEPP	John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation*
FB	Tristram Engelhardt Jr., *Foundations of Bioethics*
FCB	Tristram Engelhardt Jr., *Foundations of Christian Bioethics*

FHL	*Foundations of the Healthcare Law of the Russian Federation*
FSC	*Foundations of the Social Concept of the Russian Orthodox Church*
ICU	Intensive Care Unit
JAMA	*Journal of American Medical Association*
MLR	*Medical Law Review*
MND	Motor Neurone Disease
MTMD	Cicely Saunders and Nigel Sykes (eds.), *The Management of Terminal Malignant Disease*
NCHSPC	National Council for Hospice and Specialist Palliative Care Services
NHS	National Health Service
NSAID	Non-Steroid Anti-Inflammatory Drugs
OMM	Stephen E. Lammers and Allen Verhey (eds.), *On Moral Medicine: Theological Perspectives in Medical Ethics*
PAS	Physician-Assisted Suicide
PI	Irina Siluyanova, *Person and Illness*
PP	Paul Ramsey, *The Patient as Person*
PVS	Persistent Vegetative State
RPOMR	Russian Public Opinion & Market Research
RSMU	Russian State Medical University
SACE	Paul Badham, 'Sources of Authority in Christian Ethics'
SE	Joseph Fletcher, *Situation Ethics*
TB	*Tyndale Bulletin*
TCB	Gilbert Meilaender, 'A Texian-Constantinopolitan Bioethic'
VAE	Voluntary Active Euthanasia
VES	Voluntary Euthanasia Society
WG	Andrey V.Gnezdilov, *A Way to Golgotha: Essays on the work of the psychotherapist in oncology clinic and in the hospice*

WHO	World Health Organisation
WLS	Clare Humphreys, '"Waiting For the Last Summons": The Establishment of the First Hospices in England 1878-1914'
WW	Stanley Hauerwas, *Wilderness Wanderings*

Introduction

How one lives and how one dies have always been questions for profound reflection in the history of human thought. The technological sophistication of contemporary society has taken them out of the realm of academic studies, poetry, science fiction and personal contemplation and transformed them into a challenge of everyday reality. Modern medicine is at the forefront of this transformation. The areas of moral concern created by medical powers unheard of before have given rise to the discipline of bioethics. In the hierarchy of sciences it qualifies as 'a subspecies of ethics.'[1] Bioethics is specific enough in that most of the problems it seeks to address are being formed within the boundaries of modern healthcare environment, but in virtue of these problems it acquires a far broader scope than professional medical ethics. As a field of study it 'focuses on what is morally at stake in sexuality, the procreation of children, suffering, treating patients appropriately, establishing health care institutions, acting justly in the allocation of health care resources, and facing death.'[2] A particular way of dying termed 'euthanasia' will be in the focus of this dissertation.

This thesis is a search for personal answers to personal questions. One of my grandmothers died of lung cancer and according to my father's account her dying was filled with indescribable suffering. In the hospital they had to keep her constantly unconscious, because the moment she came to her senses it was all groaning from pain. Naturally, every time it happened my father would ask for another injection. Neither he nor the doctors knew for sure, but they had hoped they were killing the pain and for them this was the only thing to do at any rate. I often pondered what I could do for my grandmother, if anything, if I were there. Would I ever accept euthanasia as an option if I had to make a decision? First I thought that I would perhaps be inclined at least to consider it. On the other hand, something was telling me that choosing this option would be against my Christian conscience.

So it happens that both the aim and the scope of my thesis have evolved round this personal dilemma. The main task of the research that follows is to identify an authentic Christian attitude to euthanasia. In order to accomplish this task I shall seek to answer three questions:

1) what is euthanasia?

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[1] Richard A. McCormick, 'Theology and Bioethics' in Stephen E. Lammers, and Allen Verhey (eds.), *On Moral Medicine: Theological Perspectives in Medical Ethics* (Cambridge: William B. Eerdmans Publishing Company, 2nd ed., 1998), 64 [hereafter abbreviated *OMM*].

[2] H. T. Engelhardt, Jr., *The Foundations of Christian Bioethics* (Lisse: Swets & Zeitlinger, 2000), xii [hereafter abbreviated *FCB*].

2) is it incompatible with Christianity?

3) what is the alternative?

Each chapter of the thesis will in some measure contribute to the overall pursuit of these objectives, at the same time focusing on each one in particular.

Approaching the problem out of a Christian worldview, I shall concentrate mainly, albeit not exclusively, on the Christian sources. Still, the realm of Christian bioethics is so vast that in order for a particular topic within it to be covered sufficiently and consistently in a single study a certain method of enquiry should be adopted.

As the title of this thesis indicates it is a comparative analysis. Comparison as a research method has two significant advantages. First, it allows to sharpen the focus of the dissertation by choosing what to compare. This choice is exercised at several levels, going from general to particular, from broad concepts to specific instances and from definitions to distinctions. At the same time it offers an opportunity to amplify the scale of research and gives it a sense of perspective. I have chosen not to limit the evaluation of Christian patterns of thinking with regard to euthanasia by referring to the experience of a certain country or nation, but have attempted a culture bridge between my own country and the West. The technique of comparison also works to build up a 'dissertation within a dissertation' effect, constructing the theme of each chapter in a way that it acquires the potential to be developed as a research project in its own right. Thus the first chapter invites a discussion to define the term 'euthanasia' by comparing and rethinking a number of definitions from the existing multitude. The second and third chapters explore on a comparative basis two major academic frameworks that have evolved in the course of the thirty plus years' history of Christian bioethics in the West and relate their findings and problems to the emerging Russian Orthodox bioethics. The final two chapters highlight the opposition of euthanasia and palliative care approaches by examining the moral rationale behind some well-publicized end-of-life decisions and rediscovering the essence of the modern hospice movement.

What is euthanasia? Many ideas that have come to be expressed in set phrases are usually the first associations prompted by the word. Euthanasia is taken to mean "mercy killing", "personal autonomy", "death with dignity", whereas the real meaning remains obscure. The first chapter brings it to light by showing the hollowness of such slogans, which in fact are not definitions at all. The majority of them are just well sounding terms skillfully put together in a psychologically impressive manner. These terms are either too ambiguous or have too broad a range of implications to provide

trustworthy guidance. Having abandoned them, one is left with the only decisive characteristic of euthanasia – namely, the intention of medical staff to kill.

With some notable exceptions with regard to self-defence, just war, or capital punishment, Christianity has always seen taking one's own or somebody else's life as a grave sin, something profoundly wrong and indeed going against the very ethos of being Christian. This should have been enough to secure the incompatibility of euthanasia and Christianity. In the second chapter I attempt to show how it appeared to be insufficient and to explore whether there are resources for reinforcing the contrast.

Developments in medical technology in the second half of the twentieth century pointed toward the legal justification of intentional killing of the innocent – euthanasia. The challenge to Christian theology was to follow and offer moral justification by amending the sixth commandment. However, most Christian theologians felt that this would be too big a leap to make. To approve of euthanasia would be to approve of a voluntary sin. Paul Ramsey was among the first and strongest voices in the emerging Christian theological opposition. Paradoxically, however, trying to ward off the euthanasiac temptation he ended up being caught in it, as we shall see. Many an academic follower was trapped in the same way. Instead of building the opposition on a return to the sixth commandment they further let it go by trying to balance between condoning euthanasia in some cases and vigorously condemning it in others. Stanley Hauerwas sensed this ill tendency and started to reverse the whole pattern of theological thinking. He launched Western Christian bioethics on the journey back from amending the sixth commandment to learning how to live up to it. Instead of progressing in further classifications of evil that would help to get rid of the moral discomfort of killing Hauerwas insisted on facing the reality of it unabridged. The problem however was that there were a lot of Christian accounts of the way in which deadly intention is wrong, but much less preoccupation with the roots of it until Tristram Engelhardt came up with his traditional Christian bioethics. Unfortunately, the Western Christian academic tradition seems to have gone such a long way from the mind of the Church fathers of the first millennium that it will perhaps take another generation of scholars to replace Ramsey's version of the anti-euthanasia school.

Therefore it would be valuable if Engelhardt's ethics of asceticism were to spread eastwards. The third chapter is dedicated to the development of Christian bioethics in Russia. Since the fall of the communist regime opened up numerous social and technological opportunities, mainly coming from the West, it is no wonder that the perception of these changes is inevitably influenced by western experience and

reflection. The point is to decide what will be most fitting for the Russian set up. In a country with over a millennium of Orthodox Christian tradition there is an exceptional opportunity for the bioethical framework of Engelhardt to settle in naturally. The uncompromising stance of rejecting euthanasia in any form taken by the Russian Orthodox Church and generally shared by the legal authorities lacks only the kind of academic basis offered in *The Foundations of Christian Bioethics* to make for a viable standpoint on the subject.

However, in the field of bioethics even the best academic framework has a value only in relation to practice. The viability of any scholarly opposition to euthanasia has to be tested in the face of real suffering. The fourth chapter presents a number of well-publicized medical situations in Britain where choices between life and death were exercised. The analysis based on the patterns of Christian bioethical thinking discussed in the previous chapters shows most of them to be clear cases of euthanasia, while others have a recognizable potential to be described as such. Nevertheless, public opinion appears to be in a great deal of confusion about the former and altogether ignores the latter. If this happens in a country with a long-standing Christian bioethical tradition, how much more likely it is to happen in the Russian post-atheistic environment! Even if Christian bioethics in Russia starts the fight against the ethos of euthanasia from the premises outlined by Engelhardt without repeating the wilderness wanderings of its Western counterpart, it will need something more than a rightly oriented case analysis. It will not do simply to keep to the orthodox understanding of euthanasia and its incompatibility with Christianity. Any opposition survives as long as it has an alternative to offer.

A living alternative to euthanasia does exist. It is embedded in the modern hospice movement, the history and an ongoing story of which are the focus of the fifth and last chapter of this dissertation. Having started as a Christian response to the problem of suffering at the end of life, it has in the course of several decades grown into a world-wide philosophy and given birth to a new specialty of palliative medicine. So far hospices have successfully stood up against the emerging force of global euthanazation. However, the situation might change. Both pro-euthanasia supporters and palliative care specialists aim at reducing the suffering. Unfortunately, it often turns into an obsessive marathon where the former point to particular cases that seemingly admit of no solution except intentional termination of life and the latter strive to discover less radical ways out. The trouble is that there will hardly be any winners in this competition, ever. In a way those on the hospice side are already losing because the

suffering remains that does not respond even to the highest level and broadest range of palliative techniques. To keep firmly to the anti-euthanasia mindset the hospice movement should retain its core ability: to live with suffering. It is precisely this ability that sustains the opposition to euthanasia and it is essentially a Christian virtue. While any effort to reduce suffering should not be a goal in itself, now that principles of palliative care have become so much part of a religiously unidentifiable global philosophy it starts dominating. If this tendency continues, palliative services are likely at some point to give in to the fast growing pressure and turn into pre-euthanasia care. I would like to offer all that follows as a personal contribution to prevent it from happening.

CHAPTER I

REDEFINING THE DEFINITIONS

I. Introduction

The word 'euthanasia' is one that truly 'speaks volumes' nowadays. Deriving from two Greek words εὐ - good and θάνατος - death and thus having an original meaning of simply 'a good death', it has now acquired both a different meaning and quite a number of definitions. It is worth mentioning that this is due not so much to a semantic as to a cultural change. The historical linguistic development would have had an insignificant influence on the modern usage, had our society not found in the second half of the twentieth century that it can no longer agree on what is 'a good death'. Much though there is to be said about the origins of such a transformation, it is not the purpose either of this chapter or the present research. The aim is to look at the way euthanasia is defined in various contemporary sources.

I shall start with the definition of euthanasia in general, move on to the main distinction between its active and passive forms, look at the notions of voluntary, involuntary and non-voluntary, and conclude with a section on physician-assisted suicide. I shall try to show the advantages and disadvantages of the definitions adopted by different public bodies and scholars and work out my own.

II. Euthanasia: General Definitions

1. Reference Sources

To find out what is the meaning of a particular word one usually looks it up in a dictionary. Here are some of the definitions given to 'euthanasia'.

The Chambers Dictionary defines 'euthanasia' as 'the act or *practice* [my emphasis] of putting painlessly to death, *esp* in cases of incurable suffering'.[3] Even at first consideration this definition appears to be at least inadequate, if not misleading. There is no notion of who is acting or practising. One thing about euthanasia as a phenomenon that everyone seems to agree with, is that it is a specifically medical practice. It would have been more precise for this definition to state that euthanasia is

[3] *The Chambers Dictionary* (Edinburgh: Chambers Harrap Publishers Ltd, 2nd ed., 2001), 558.

the 'act or practice of members of the medical profession'. It is also puzzling why 'acting' is not included in 'practice', which is obviously a broader concept, accommodating both acts and omissions. The distinction between them, as we shall see later on, is qualifying different kinds of euthanasia. And finally, the notion of suffering as well as incurability is highly elastic and subject to a vast number of interpretations.

Another contemporary reference source, *The New Encyclopædia Britannica*, gives the following definition: 'euthanasia' is an 'act or practice of painlessly putting to death persons suffering from painful and incurable disease or incapacitating physical disorder'.[4] The 'act or practice' may lead one to think that the author of the article also composed the entry for *The Chambers Dictionary*. As to the 'painlessness' of putting to death, the 'practice' itself has already shown in cases like that of baby John Pearson and Tony Bland that it is a highly questionable characteristic of euthanasia. Furthermore, this definition affords the notion of suffering to embrace a concept of mysterious 'incapacitating physical disorder'. One might want to ask what would that be? Also, why does it have to be 'physical'? Would not 'mental' or 'psychological' be equally fitting? The evidence is that they already are.[5] In short, the definition in the *Encyclopædia* in terms of clarity and accuracy is no better than the one in the *Dictionary*.

Are these ambiguities and inaccuracies a fault of general dictionaries? If euthanasia is a medically related term, it is worth consulting specialist dictionaries.

In the *Dictionary of Medicine* one finds the most apt definition of euthanasia: 'mercy killing, the killing of a sick person to put an end to his suffering'.[6] The absence of the specific context in the definition itself can be justified on the grounds that the area covered by the dictionary implies a medical context. 'Killing' is just a concise substitution for 'putting to death'. The only somewhat imprecise notions are 'sick' and 'suffering'. Should sickness and suffering be of a mental or a physical character, or both?

Black's Medical Dictionary, perhaps one of the most popular, is even less precise about the context, and even more inaccurate in its terminology. It defines euthanasia as 'the procuring of an easy and painless death'.[7] Once again, according to

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[4] *The New Encyclopædia Britannica*, 15th ed., Vol.4, 610.
[5] The Dutch cases of Dr Chabot and Dr Sutorius described in John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge: Cambridge University Press, 2002) [hereafter abbreviated *EEPP*].
[6] *Dictionary of Medicine* (Cambridge: Peter Collin Publishing Ltd, 3rd ed., 2000), 155.
[7] *Black's Medical Dictionary* (London: A&C Black Limited, 39th ed., 1999), 190 [hereafter abbreviated *BMD*].

the current data euthanasia can no longer in good faith be described as 'easy and painless'. To do justice to the account in *BMD,* the text that follows the initial summative definition tries to give the reader an idea of the major issues at stake by providing an extended description of what the euthanasia debate is actually about. And the debate is, after all, about whether 'a medical practitioner ... should have the power to put to death any person suffering from a painful, distressing and incurable disease'.[8] However, it has to be emphasized that whether a person who is the object of euthanasia suffers and whether the disease is painful, distressing, or incurable or all of these at once, is irrelevant for the definition of euthanasia. It is relevant for the guidelines in practising it.

2. Voluntary Euthanasia Society

After examining the reference sources and finding their definitions of euthanasia not exactly satisfying, one might want to turn to a specialist opinion. It would be most natural to think that the materials of the Voluntary Euthanasia Society (VES) would give a definition that reflects accurately and exhaustively the meaning of this term, which it has obviously been set up to promote.

The VES definition reads: 'Voluntary euthanasia is the ending of the life of another person at their request'.[9] Leaving out the word 'voluntary' for the purposes of generalization, the reader is faced with a definition of assisted suicide, which stands for cases like that of Diane Pretty. To qualify as euthanasia 'the ending of life' should be performed by someone like Dr Cox or Dr Arthur. Moreover, the above definition has nothing to do either with particular medical decisions at the end of life, which euthanasia is still mainly about, or with suffering and dying as such. It must be said that further in the text some specifications appear. The VES sets out its aim to change the law in the UK 'so that competent adults, suffering unbearably from an incurable illness, would be able to receive medical help to die at their own considered and persistent request'.[10] Also, on the same website, a more precise definition can be found, curiously enough under the heading of *Physician assisted suicide* and serving to explain the difference between the two: 'Voluntary euthanasia is where a doctor administers a lethal injection at the patient's request'.[11] Even more interesting is the fact that euthanasia as

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[8] *BMD*, 190.
[9] THE DEBATE *Voluntary Euthanasia,* http://www.ves.org.uk/Deb_VolEuth.html (29 June 2002).
[10] Ibid.
[11] THE DEBATE *Physician assisted suicide,* http://www.ves.org.uk/Deb_PhyAssSu.html (29 June 2002).

such, without any reference to its active or any other form, is finally defined in the IN DEPTH section under the heading of *Factsheets on voluntary euthanasia.* Informing the reader about the Greek origin of the word and admitting that today the meaning 'has widened to include how that good death is brought about', the section goes on to describe euthanasia as 'a good death brought about by a doctor providing drugs or an injection to bring a peaceful end to the dying process'.[12] Such a variety of definitions, which sometimes hardly square with each other seems to bring more confusion than clarity into the question. It remains somewhat uncertain whether euthanasia occurs

a) when someone ends the life of another person at their request;
b) when a doctor gives a lethal injection at the patient's request;
c) when medical help is provided for a competent adult to die at their own considered and persistent request;
d) as a good death provided by a doctor giving either drugs or an injection.

All of these are apparently different concepts and if each one of them was intended to complement the others there is still some doubt whether this intention has succeeded. Apart from the first one, the definitions presented consist almost entirely of notions that will themselves require further defining, which makes the understanding of what euthanasia is about even more complicated. For example, it is not possible to tell from the options presented whether any request would qualify for euthanasia or only a considered and persistent one, or both. Or, alternatively, maybe there are other requirements that should be met for the request to become valid? Should medical help be confined to a doctor, or is it a broad enough concept to include nurses and, perhaps, medically trained caregivers? Last, but not least, one should definitely distinguish between 'medical help to die' and 'medical help in dying'. There is a wide difference between the two, which can be easily overlooked. The former implies bringing a certain process about, and the latter aid in going through it.

3. The Netherlands

Since the VES does not, as one would have hoped, improve on the general reference sources in developing a clear definition of euthanasia, it is probably worth consulting another major authority, the Dutch. In 2001 the Netherlands became the first country fully to legalize euthanasia. Moreover, it has for a long period of time been the place in the world where it has been most widely practised. Whereas the VES is so far

[12] IN DEPTH: factsheets, http://www.ves.org.uk/DpFS_Intro.html (29 June 2002).

only fighting for a change in the law, the Dutch have already changed theirs and thus would supposedly be much clearer in defining what it now allows.

The State Committee on Euthanasia in 1985 gave the following definition: 'Euthanasia is the intentional termination of a patient's life by someone else on request of that patient'.[13] Although it seems to be to some extent more precise than the definitions that have been discussed above, it still leaves room for various interpretations. First, it is totally unclear who is understood by 'someone else': a doctor, a spouse, a relative, a friend or a passer-by? Again, let me remind the reader that stripped of a direct relation to a medical context, this definition would simply stand for assisted suicide. Marianne Daverschot and Hugo van der Wal in their article about the Dutch experience in *Ethics & Medicine* specify that 'the performance of euthanasia is restricted to physicians'.[14] It would seem to me to be more appropriate to include this specification in the definition itself. The second problem lies in bringing the condition of a patient's request into the definition. The existence of a request is an attribute of voluntary euthanasia and thus is not quite fitting for defining the term in general. As will be shown in due course, termination of a patient's life without their request would still remain euthanasia. However, it has to be mentioned that 'euthanasia is always defined in the Netherlands as voluntary active euthanasia'.[15] Although the Dutch practice shows there is unarguable evidence of non-voluntary and involuntary euthanasia,[16] it is not for us to go deeper into it for the time being. What is good about the Dutch definition is that it characterizes termination of life as 'intentional'. Without this, the definition might as well apply to clinical mistakes and mere negligence, which would describe instances of a different kind, not euthanasia. Of course, the notion of 'intention' is open to a number of interpretations and brings certain problems of its own into the debate, but those will be dealt with later on.

4. Academic Sources: John Keown

In the 1960s bioethics became an academic discipline. Since that time huge numbers of eminent scholars have tackled the subject of euthanasia, among them philosophers, theologians and ethicists. All of them have tried to define euthanasia in

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[13] Marianne Daverschot and Hugo Van der Wal, 'The Position of Nurses in the New Dutch Euthanasia Bill: A Report of Legal and Political Developments', *Ethics & Medicine*, Vol 17:2, Summer 2001, 86 [hereafter abbreviated *E&M*].
[14] Ibid, 87.
[15] Ibid, 86.
[16] See, for example, the most recent research into the matter in *EEPP*.

their own way. Being unable to reproduce the whole variety of definitions, distinctions, concepts and commentaries offered by the academic world, I have chosen to look more closely at what John Keown has to say. Lecturing in the Law and Ethics of Medicine he is probably one of the few academic scholars in Britain who has a thorough knowledge of the Dutch euthanasia practice. His recent book, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation*, while particularly concentrating on the evidence in favour of the 'slippery slope' argument against decriminalization of euthanasia, also contains a careful and exhaustive framework of definitions and distinctions. It is a very appealing attempt to find 'a path through the thicket of contradictory interpretations',[17] not only of the Dutch experience, but of euthanasia as a concept in general. The introduction to Part I is so sharp and at the same time so simple that it merits quoting in full:

> The euthanasia debate is riddled with confusion and misunderstanding. Much of the confusion derives from a failure of participants in the debate to define their terms. Part I seeks to clarify the confusion by noting some of the differing definitions in the current debate, indicating the underlying moral distinctions they reflect, and assessing their relative merits.[18]

Acknowledging that there is no one universally agreed definition of euthanasia, Keown insists that 'it is vital to be clear about how the word is being used in any particular context',[19] rightly pointing out that otherwise any discussion is senseless and frustrating. He presents three different meanings. They are:

- *active intentional* termination of a patient's life by a doctor who thinks that death is a benefit to that patient;
- *intentional* termination of a patient's life *by act or omission* by a doctor who thinks that death is a benefit to that patient;
- *intentional or foreseeable* termination of a patient's life *by act or omission* by a doctor who thinks that death is a benefit to that patient.

All the three meanings have three specific features in common. They characterize decisions which:

- have the effect of shortening life;
- are set within a medical context;

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[17] *EEPP*, 4.
[18] Ibid, Part I. Definitions (7).
[19] Ibid, 9.

- concur in the belief that a patient's death is a benefit (and, one might add, the only one left). [20]

As follows from the contents of the book, the author adheres to the second definition, consistently arguing the narrowness of the first and the distortion of the third.

As we have already had numerous chances to affirm the importance of 'intention' in defining euthanasia, it would be useful to dismiss any misperception of the meaning of this word. Therefore probably the strongest concept introduced by Keown is the difference between intention and foresight. In short, it is the difference between 'aiming to bring about a consequence' and 'simple awareness that it may or will occur'.[21] This is an important distinction, and Keown provides many persuasive illustrations of the differences between the two. However, as we shall see, it is also important to note that it can be difficult to detect what a person's intentions are. Indisputable as it is that 'it is by no means always difficult to decide whether someone intends a consequence or not', because 'there is often the evidence of what they say and/or what they do',[22] it is nevertheless necessary for us to keep in mind that there are cases where difficulty can emerge in distinguishing between what people intend and what they say and/or do.

5. Proposed Definition

From the above examples, taken from a variety of sources, it is quite clear that one of the things one should do to define euthanasia is to avoid set phrases and notions that are as misleading as they are widespread. 'Easy and painless death', 'terminal illness', 'unbearable suffering' have all become slogans rather than meaningful concepts. They appear to have very little to do with euthanasia as such. They set one off on the track of 'intellectual "catch-22" '[23] and cause a totally frustrated 'hit and miss' debate. Although Keown considers belief in death as benefit to the patient to be an important prerequisite of euthanasia, I prefer to exclude it from my definition. As discussion of Dr Shipman case will show in the fourth chapter of this thesis euthanasia does not have an absolute association with 'mercy killing'.

What a definition of euthanasia should, in my view, necessarily include, is the medical context. Here I am wholeheartedly with Keown in believing that 'euthanasia

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[20] Ibid, 10.
[21] *EEPP*, 18.
[22] Ibid.
[23] Ibid, 30.

involves patients' lives being shortened by doctors and not, say, by relatives'.[24] As was mentioned before, if a doctor ends the life of someone other than a patient by medical means which he is professionally aware of and has access to, even if he is not on duty at the time, this is simply killing, not euthanasia. Equally, if, for example, a vicious relative of the patient steals an ampoule of potassium chloride and makes an injection when there is nobody on the ward, it would qualify as murder, not euthanasia.

If more support should be lent to the necessity of the medical context, there are historical reasons for it. Most of the candour that the word 'euthanasia' acquired in its modern usage stems from the data revealed at the Nuremberg trial about the state medical programme of 'killing the worthless' in fascist Germany in 1939-1941. Also, paraphrasing Tristram Engelhardt in his usage of the classical account of causation in the law developed by Hart and Honoré, the dying of patients is decisively relevant within a practice in which doctors discharge particular duties of caring for patients in hospitals.[25] The only expansion that I am inclined to make is that on the account given there are no reasonable grounds to confine euthanasia to physicians and exclude nurses[26] other than the current practice of professional subordination.

Another crucial component of the definition should be intention. Although it can give rise to its own problems of detection and judgement, it simply allows one to distinguish between euthanasia and the cases of inevitable medical mistakes, incompetence and negligence.

Drawing on all that has been said my definition of euthanasia is: medical staff intending the death of a patient. [27]

III. Distinctions

Euthanasia is a complicated phenomenon, as it occurs equally in acting and in failing to act on part of the medical staff. In the following section I shall draw out this important distinction and give an overview of what it can imply.

1. Active Euthanasia

Active euthanasia consists in medical staff intending the death of a patient by doing something[28] and hence includes:

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[24] Ibid, 10.
[25] *FCB*, 320. See also footnote 41 of Chapter 6.
[26] As it is obviously the case in the Netherlands: *E&M*, 87.
[27] Acts and omissions belong to the distinctions that follow.
[28] The preference I give to this simplistic phrase will be justified in due course.

- intentionally giving an injection of a substance which has no curative or analgesic properties[29] or an overdose of a pain-reliever lethal in itself (cases of Dr Cox and Dr Shipman);
- intentionally giving any type of oral medication which has no curative or analgesic properties or an overdose of it lethal in itself;
- withdrawing medical devices with intention to cause death (the case of Tony Bland).

Whereas the first two instances clearly belong to the active form of euthanasia, the third one is usually attributed to its passive form.[30] I think this is a mistake, if by 'withdrawing medical treatment' one means 'withdrawing medical devices', which are often described as 'life-sustaining'. One is precisely acting, i.e. doing something when one switches off artificial ventilation, or a heart-lung machine, or removes a nasogastric tube. It is an action, not an omission.

Again, it must be stressed that to qualify for euthanasia, withdrawal should be aimed at death. Not *any* withdrawal is euthanasia. There are diseases which result in the patient's inability to breathe at night unless they have a ventilation machine, but they breathe absolutely freely during the day.[31] Obviously, 'withdrawal' of ventilation machines in the mornings does not constitute euthanasia. Another example is Duchenne muscular dystrophy, a condition which requires a specific type of ventilator to *help* the patient's breathing, not to substitute for it. These examples show that one should be very careful in generalisations such as saying that 'ventilation replaces the patient's capacity to breathe'.[32]

2. Passive Euthanasia

Passive euthanasia consists in medical staff intending the death of a patient by doing nothing and hence includes:

- withholding an injection with intention to cause death;
- withholding any type of medication with intention to cause death;
- withholding medical devices with intention to cause death;
- stopping or not starting nutrition and/or hydration that can be provided without the help of medical devices.

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[29] As it was the case with Dr Nigel Cox. See *EEPP*, 11-12.
[30] The distinction adopted among others (or following others?) by John Keown.
[31] My interview with Margaret Hickie, Senior Nurse at the Rainbow Family Trust, Manchester, 17 June 2002.
[32] *EEPP*, 220.

Here it has to be commented that contrary to withdrawal, withholding is rightly categorized as 'passive', because it presupposes literally 'not doing anything' or 'doing nothing'. A good example for the last of the listed instances is the Dr Leonard Arthur case.[33]

3. Voluntary, Non-Voluntary and Involuntary Euthanasia

Further distinctions in the form of euthanasia are related to the participation of the patient in it. Medical staff can intend the death of a patient by doing something or by doing nothing

- according to the patient's request (voluntary euthanasia);
- without the patient's request (non-voluntary euthanasia);
- against the patient's will (involuntary euthanasia).

The first and the last distinction apply to so-called 'competent' patients. As the notion of 'competent' is quite loose due to the difficulties in assessing 'competence' and to its changeable nature, the distinctions would typically include those patients that are *not* in coma, PVS or severe dementia. The second distinction would apply to those who have one of these conditions, and to newborns.

IV. Physician-Assisted Suicide

There is little if any difference between voluntary euthanasia and what has become to be known as physician-assisted suicide (PAS). The difference is usually thought to be in the mode of doctor's participation in the death of the patient. If in euthanasia it would be the doctor who makes the injection or turns off a medical device with intention to cause death, in PAS the doctor would only provide the syringe or point to the appropriate switch. Probably the most notorious example of PAS is the practice of Dr Jack Kevorkian, for which he has received the horrifying tag 'Dr Death'.

Among the arguments in favour of the alleged difference between euthanasia and PAS are:

- the patient, not the doctor, remains in control till the very end;
- there is more time for the patient to change his mind.

To these Keown cites counter-arguments. Even in PAS he says, according to the opinion of many, 'whether assistance is given will depend on the decision of the doctor,

[33] David J. Atkinson, 'Causing Death and Allowing to Die', *Tyndale Bulletin* 34, 1983, 201-28 [hereafter abbreviated *TB*].

not the patient'.[34] Secondly, if the patient's autonomy is what matters, why should it not be equally respected in voluntary euthanasia?

> Thirdly, the physical difference between intentionally ending the patient's life, and intentionally helping the patient to end his or her own life, can be negligible. What, for example, is the supposed difference between a doctor handing a lethal pill to a patient; placing the pill on the patient's tongue; and dropping it down the patient's throat? Where does PAS end and VAE [Voluntary Active Euthanasia] begin?[35]

Indeed, this difference is difficult to trace even in the physical world and it is definitely non-existent in the moral world.

[34] *EEPP*, 33.
[35] Ibid.

CHAPTER II

FROM THE ETHICS OF COVENANT TO THE ETHICS OF ASCETICISM

I. Introduction

Christian bioethics as a theological discipline emerged in the 1960s. In the West the failure of natural law styles of thought and the rapid decrease of the church as an important public institution were amongst factors that led theologians to search for new grounds on which to establish themselves in bioethics. These were found in using Christian presuppositions and values but stripping them of the context of tradition and community to which they once belonged. Joseph Fletcher and Paul Ramsey initiated this trend, although they probably could not have imagined the consequences that were to follow, in particular the difficulty of distinguishing between Christian bioethics and secular bioethics, so much lamented later by James Gustafson and constantly emphasized by Stanley Hauerwas. The question of where it all went wrong began to bother the brightest theological minds and the need for a candid Christian bioethics was finally re-established. In the second chapter of my thesis I will show how this happened in the form of a comparative study of the ethics of Paul Ramsey and the ethics proposed by Tristram Engelhardt.

II. Paul Ramsey and the Ethics of Covenant

1. Concept of 'Fidelity to Covenant'

In the Preface to *The Patient as Person*, Ramsey states: 'This...is a book...written by a Christian ethicist.'[36] It is the statement that is supposed to put one in the right perspective for reading all that follows. Whether this is what actually happens will be examined further.

The principle which will prove central for the whole book is a Biblical norm, referred to as 'fidelity to covenant'. There is no room left for ambiguity in the reader's understanding of this covenant as that between human being and God. From this major

[36] Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics* (New Haven: Yale University Press, 1970), xi [hereafter abbreviated *PP*].

covenant all the 'canons of loyalty' between person and person emerge. So, ultimately, we are not only in covenant relationship with God, but in no smaller measure with all the people that we happen to come across in our life. Ramsey explicitly shows from the very first pages that covenants between persons are crucial for any kind of relationships we develop, whether those we are born into or those we enter by choice. These covenants are reflections of that great eternal one. And Ramsey regards medical practice as the most powerful and explicit among them.

In the light of this concept the very nature of human relationships is that of trust, not dominion, as many of us are so eager to see it. The subject of our trusteeship is life itself. The question follows: how are we supposed to understand life? Ramsey clearly speaks about its meaning in his *Ethics at the Edges of Life*, where he acknowledges that life is a gift, which is to be received with gratitude and to be treasured and cherished. Thus every man is a person because he is 'an embodied soul or ensouled body' and every person is 'a sacredness in bodily life.'[37] The latter expression brings us to the meanings of sacredness and sanctity. Ramsey sees sanctity as an essential characteristic of the phenomenon of human life and sacredness as a characteristic of each human being bearing 'a touch of sanctity.'[38] These two co-exist and in a certain sense overlap in securing each other:

> The sanctity of human life prevents ultimate trespass upon him [the person] even for the sake of treating his bodily life, or for the sake of others who are also only a sacredness in their bodily lives.[39]

A careful reader of Ramsey will notice, as Hauerwas did,[40] that theology in *The Patient as Person* surprisingly ends in the Preface. Although he declares in the opening that he writes as a Christian ethicist, there is nevertheless nothing within the book to support this statement. Fidelity to covenant on its own can with equal success be employed for example by an ethicist coming from a distinctively Jewish or Muslim tradition. I suggest that there are three identifiable reasons – although many are possible – why Ramsey did not work through his theological basis properly.

First of all, his book was intended to show that it is 'necessary for an ethicist to go as far as possible into the technical and other particular aspects of the problems he

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[37] *PP*, xiii.
[38] Ibid.
[39] Ibid.
[40] Stanley Hauerwas, 'How Christian Ethics Became Medical Ethics: The Case of Paul Ramsey', in *Wilderness Wanderings* (Boulder, Colorado/Cumnor Hill, Oxford: Westview Press, 1997), 128 [hereafter abbreviated *WW*]. It should be noted though that such non-theological reading of Ramsey is a subject of disagreement among Christian theologians. See: Oliver O'Donovan, 'Keeping Body and Soul Together', in *OMM*, 223-38.

ventures to take up'.[41] The way he did this in my view makes him one of the best ethicists of the twentieth century. A good book on ethics is not the one that gives answers but one that skillfully puts thought-provoking questions. *The Patient as Person* is definitely in this category. Also, the depth of Ramsey's knowledge of specific medical issues is as admirable as it is rare for a theologian. On the other hand, this digging to the technological roots has unfortunately been purchased at the price of theological shallowness. After all, what is the main characteristic of covenant? If it is to resemble God's bond with his people, then it has to be everlasting. It seems that using the language of covenant and not of contract was meant to emphasize an endless 'faithfulness to a fellow man',[42] in the image of God's enduring commitment to his people. As we shall see, covenant for Ramsey has its limits. No matter how significant is the fact that he holds 'with Karl Barth that covenant-fidelity is the inner meaning and purpose of our creation as human beings'[43], it is apparently insufficient to secure theological, let alone Christian grounds for bioethics. Perhaps Ramsey's biggest tragedy was that despite his strong demand to be treated as a Christian ethicist, his writings were more often than not taken as a model for shaping a common denominator.[44]

The second reason for the theological convictions being so poorly articulated was that the author believed that the remnants of basic Christianity were still present in society as a whole. Thus, he assumed that there was no great need to go deeper into the theological background. In his essay of 1982, 'Tradition and Reflection in Christian Life', Ramsey admits:

> Those who still address counsel to governments must believe *either* that a remnant of the Christian age remains on which they count when testifying before Congress *or* that in so doing they do so as only one among many other voices in a society that for the foreseeable future is irredeemably secular...It is in this sense that I continue to try to do "public ethics"...At the same time I continue to try to do "church ethics" in hope that the day may come when the dominant secular viewpoints on morality will be extended from the church of Jesus Christ.[45]

Apparently, Ramsey was in a certain sense saving his deeper theology for that day to arrive. Remarkably, somewhat thirty years after *The Patient as Person,* the appearance of Engelhardt's *The Foundations of Christian Bioethics* indicated the failure of this hope.

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[41] *PP*, xii.
[42] Ibid, xiii.
[43] Ibid, xii.
[44] This problem has been somewhat sarcastically presented in a form of a 'medical case' by Stanley Hauerwas in *WW*, 124-6.
[45] Quoted in *WW*, 129-30.

Finally, in struggling to locate the framework he has developed, Ramsey partly could not and partly did not want to see the church as an appropriate *locus* for it.[46] The reader would have to make a considerable effort to work out that Ramsey belongs to the Methodist tradition. The ethics of covenant seemed to be successfully institutionalized in medicine itself, leaving the church as an institution out of the equation. Although Ramsey wholeheartedly believed 'that Christian special ethics would still come to the conclusions I do',[47] in the long run this principle has betrayed him. For some of the conclusions are different. They are conclusions belonging precisely to secular, not to Christian ethics.

2. Defining Death

The question of death appears to be the most interesting and important for Ramsey in addressing the problem of euthanasia. It is not by chance that the third chapter of *The Patient as Person* is treated as one of the most significant pieces of his work.[48] It would be only to do justice to 'On (Only) Caring for the Dying' to say that it is an eye-opener in many respects, especially in its breath-taking deep insight into the specifically medical and technical aspects. In our age of oversophisticated medical hi-tech it sometimes becomes difficult to establish whether the person was actually alive before euthanasia has taken place.

Before undertaking a closer examination of what Ramsey has to say about defining death, I shall turn to his theological explanations of its meaning. Ramsey holds that 'as Christians we believe that death is the "last enemy" that shall be destroyed.'[49] He argues, in accordance with what has been said earlier about the Christian understanding of life, that to choose death as an end would be 'to throw the gift back in the face of the giver.'[50] This may be too emotionally expressed, but it still makes perfect sense. 'Vitalism' does not, as it may seem, automatically follow. On the contrary, when a person is refusing to choose death as an end, his choice is rather about 'how to live

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[46] For an extended explanation of this life-long search see: D. Stephen Long, *Tragedy, Tradition, Transformism* (Boulder: Westview Press, 1993), 131-3.
[47] Letter to Stanley Hauerwas quoted in *WW*, 131.
[48] See: David H. Smith, 'On Paul Ramsey: A Covenant-Centered Ethic for Medicine', in Allen Verhey and Stephen E. Lammers (eds.), *Theological Voices in Medical Ethics* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1993), 7-29.
[49] Paul Ramsey, *Ethics at the Edges of Life* (New Haven and London, Yale University Press, 1978), 147 [hereafter abbreviated *EEL*].
[50] *EEL*, 146.

while dying.'[51] Indeed, it is one of the life choices. Ramsey aptly describes what we actually have to compare:

> ...a certain state or condition of dying with another, one treatment with another, or treatment with no treatment. All such decisions are consistent with accepting life as a gift and a trust. None seizes dominion over human life and death.[52]

Now it seems to be quite clear that from the point of faith, we as a community of persons are called to fight against our 'last enemy', not desert to it, until we can join God in his victory and peacefully surrender to Him our earthly lives. Speaking metaphorically, life is a long conversation for us to take part in as actively and wholeheartedly as we can, but it is never an argument where the only way for us to be right is to have the last word. It belongs to God and does not subject us to humiliation, but bestows honour and glory upon us as faithful stewards and trustees.

Some wise people in Soviet times taught that to fight successfully one has to know one's enemy. What, then, do we know about death? Ramsey shows our striking ignorance, despite all the sophisticated and regularly updated medical criteria. In some sense, we are still struggling through the scientific thicket being constantly caught in the brambles. At the beginning of chapter two in *The Patient as Person* Ramsey gives the following definition of death:

> Life means the functioning of the integrated being or physiological organism *as in some sense a whole* [Italics added]. Death means the cessation of this functioning. This in turn depends on the integrated functioning of certain great organ systems.[53]

The last phrase of the quotation opens up the question of what we nowadays regard as 'integrated functioning'. Can we still apply that definition in the cases where one or more of the great organ systems are kept functioning only by artificial maintenance of the other(s)? Ramsey does not give a straight answer and all his examples and explanations tell us there is none. He tells the story of a Boy Scout leader, applying artificial respiration trying to save the life of a boy, whose brain is cleaved in two. It is wrong to think that when after several hours the leader gives up exhausted the boy is still alive. It would be misleading, Ramsey insists, to say that 'the leader stopped respiration while the heart still beat' in exactly the same way that it would be to assume 'that he stopped respiration while the boy still breathed.'[54] Transferred to the hospital, this story would have had the only difference in replacing the Scout leader who finally

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[51] Here Ramsey quotes Arthur Dyck of Harvard University.
[52] *EEL*, 148.
[53] *PP*, 59.
[54] Ibid, 67.

got tired with a respirator that can virtually go on forever. The other side of the problem comes up in another example brought to our attention: people with 'pacemakers'. Are they already dead or still alive? If we subscribe to the view that one of the great organ systems sustained remotely by external means through another great organ system is not to be qualified as a sign of life, then our answer should be 'dead'. But one cannot possibly deliver such a verdict without getting oneself into trouble. Ramsey puts it this way:

> It may be granted that an essentially isolated brain *life* may be quite enough to warrant continuing by any means procedures that alone indefinitely stay the abolition of that brain. The question raised by the current discussion is quite different: it is whether an essentially isolated brain *death (or* some tests for this) are enough to warrant ceasing to treat a patient as a man alive and stating that death has occurred in the presence of continuing natural functioning of either lungs or heart.[55]

He insists that '*further updating* the updating of death' is needed. Ramsey reminds about the danger of two possible confusions that are likely to occur consciously or unconsciously.

> A decision to continue or to discontinue life-sustaining treatment of a person who has suffered massive brain injury, or longer to sustain a comatose patient, or a conscious dying patient, is precisely a judgment made in the face of a life still present.[56]

The second confusion is to mix up death with 'organ donor eligibility'. It triggers the temptation to cheat in stating death for the sake of achieving organ donor status. And if this happens within the traditional moral framework, we will have to recognize that an eminent pro-euthanasia philosopher Peter Singer has a point in saying that those who defend the sanctity of human life are simply patching up the holes in the doctrine by redefining death 'so that they can remove beating hearts from warm, breathing bodies, and give them to others with better prospects, while telling themselves that they are only taking organs from a corpse'.[57] The moment of one's death should never be an adjunct to another's life. Neither should definitions be updated with that kind of aim in mind.

Summing up the problem of defining death, the crucial understanding that emerges is the uncertainty of the borderline between life and death and the only morally justifiable guideline is drawn:

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[55] *PP*, 96.
[56] Ibid, 99.
[57] Peter Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics* (Oxford: Oxford University Press, 1995), 188.

> *Since we do not know the borderline between life and death*, nothing less than the maximum definition of death will do – brain death plus heart death plus any other indication that may be pertinent – before final violence is allowed to be done.[58]

3. 'Euthanasiac acts and sentiments'

Anybody who has read *Ethics at the Edges of Life* would never again feel very comfortable using the term euthanasia. Ramsey says the meaning of the word has been corrupted by its current usage. Euthanasia has become a negative tag as it tends to imply 'choosing death as an end.' This kind of choice is totally unacceptable for Christians. The original meaning of euthanasia appears to have been lost and there is no hope of restoring it in its own right. Instead it is hedged about with inventive distinctions like 'active' or 'passive', 'direct' and 'indirect', 'voluntary' and 'non-voluntary' mainly for the purpose of solving the old philosophical puzzle of whether there is a moral difference between acts of commission and acts of omission. For Ramsey it all went totally wrong precisely when that new 'corrupted' meaning was assigned to euthanasia. Therefore he claims he will 'get rid of all those terms.'[59] I cannot tell whether he succeeded; perhaps he did at that time. Perhaps it was worth a try in 1978, but since we find ourselves in a new century stuck with the same 'corrupted' meaning, evidently his success did not last long. One of the reasons was probably a lack of basis for the claimed difference between 'euthanasiac acts and sentiments' and the ethics of care. The whole course of developing the latter ends up in accepting what it has so vigorously rejected in the beginning.

For Ramsey the only meaning of euthanasia is 'dying well enough' according to the concept of 'fidelity to covenant' and to the 'faith that life is a gift.' Anything that fails to stand up to these is instantly reduced to mere 'euthanasiac acts and sentiments.' Bearing a somewhat pejorative connotation this phrase, as it seems to me, catches the heart of the matter further on, when Ramsey states that 'a religious outlook that goes with grace among the dying can never be compatible with euthanasiac acts and sentiments'.[60] While all this is extremely fair, it is nevertheless far from clear what this religious outlook stands for. If it is merely grounded in covenant and 'giftedness of life', it is too weak to withstand the wind of change, from whichever side it comes.

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[58] Ibid, 110.
[59] *EEL*, 146.
[60] *PP*, 153.

4. Curing and Caring

One might ask what are we left with after dismissing the ethics of euthanasia in its modern sense. Ramsey just fits it all into a single sentence, saying that 'in caring for the dying, *we cease doing what was once called for and begin to do what is called for now*'.[61]

What is happening in the world of medicine now as well as in people's minds seems to reflect that we are no longer able to make that passage to only caring for the dying. Or, to put it more accurately, society is totally confused about the implications of it. Thus it is only natural that the ethics of only caring for the dying, which really is no less than our traditional medical ethics, meets opposition from two sides. Ramsey calls them 'extremes.' To put it simply, they are 'vitalism' and euthanasia. People are torn between them while they opt for one or the other, failing to see the middle way. The ethics of only caring for the dying avoids the perils of 'vitalism':

> We need rather to discover the moral limits properly surrounding efforts to save life. We need to recover the meaning of only caring for the dying, and the justification – indeed the obligation – of intervening against many a medical intervention that is possible today.[62]

Such an intervention can come in the form of distinguishing between ordinary and extraordinary means. Paradoxically the whole history of medical technologies can be characterized as converting extraordinary means into ordinary (customary) ones. Therefore the problem is not in deciding which set of means is morally justified. For the morality of only caring for the dying, Ramsey argues, there is no moral obligation to apply useless means, be they ordinary, natural or customary in practice. This is one of the foundation stones. Another crucial point is that '...the description of human acts of caring for the dying ...terminates in the man who is the patient of these ministrations and not in the disease or diseases he has.'[63] In other words, our care does not stop when we cannot cure, it still continues or rather truly begins beyond the efforts of curing. This is precisely what the opening quotation in this section is telling us. We have to stop for a minute in the dashing marathon of conquering illness or 'striving officiously to keep alive'; and see the person, who is desperately trying to reach for our covenant partnership and crying out for company in the cold wilderness of advanced medical

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[61] *PP*, 159.
[62] Ibid, 118.
[63] Ibid, 132.

technologies. As Dr Elizabeth Kübler-Ross sharply noticed, the patient is slowly but surely 'beginning to be treated like a thing':

> He may cry out for rest, peace, dignity, but he will get infusions, transfusions, a heart machine, or a tracheostomy. He may want one single person to stop for one single minute so that he can ask one single question – but he will get a dozen people around the clock, all busily preoccupied with his heart rate, pulse, electrocardiogram or pulmonary functions, his secretions or excretions, but not with him as a human being.[64]

All this said, one might wonder how the ethics of care manages not to coincide with what we would now mean by euthanasia. Misinterpretations do happen. There is an example in the writings of Joseph Fletcher, who 'wishes to subscribe both to an ethics of caring, but only caring, for the dying, and to euthanasia in its current meaning.'[65] Ramsey vigorously rejects that kind of 'cocktail.' Even the phenomenon of ambiguity in using pain-killing medication, known as 'the principle of double effect', does not shift caring for the dying to some sort of 'indirect' or 'involuntary' euthanasia. In Ramsey's view the life-shortening effect of pain-relieving drugs is not as self-evident as it is often assumed. Intense unrelieved pain may equally shorten the patient's life, and if we are not providing available medication to alleviate it, are we not doing something more 'euthanasiac'?

Having described and affirmed the concept of 'only caring for the dying' it is time to see whether Ramsey makes any exceptions or sets any limits to that care. In other words, is there a boundary beyond which our efforts are in vain? Ramsey thinks there is. The first case of crossing the border would apply to those who are no longer capable of receiving our care. In relation to the covenant principle, some conditions, such as patients in deep and irreversible coma maintained alive for many years, can be regarded as having fallen out of the covenant bond between person and person. To be in the covenant partnership both parties have to be aware of it. Ramsey sees 'no contradiction to withhold what *is not capable of being* given and received.'[66] In other words, at this point covenantal relationship starts to look suspiciously like an expired contract, where one of the parties not being able to participate automatically terminates it. This is how the ethics of covenant unintentionally turns simply into the ethics of consent.

The second suggested case concerns patients whose dying is prolonged when medication fails to keep acute pain at bay. Reminding us that it is not for moralists to

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[64] Elizabeth Kübler-Ross, *On Death and Dying* (London: Tavistock Publications, 1970), 8.
[65] *PP*, 149.
[66] Ibid, 162.

determine whether such cases exist, Ramsey proposes that patients with bone cancer might fall into that category. These two situations are qualified as exceptions to the rule of always caring for the dying, or rather for Ramsey they are the areas where this rule does not apply any more and thus even positive action towards the end of life can be taken:

> One can hardly hold men to be morally blameworthy if in these instances dying is *directly accomplished or hastened* [Italics added]. ... A patient undergoing deep and prolonged pain, who cannot be relieved by means presently available...would also be beyond reach of the other ways in which company may be kept with him and he be attended in his dying – as much so, depending on the degree of his undefeatable agony, as the prolonged comatose patient.[67]

Astonishingly, if one brings together one of the previously quoted statements and the conclusion above, the result is a moral acceptance of intentional killing or active euthanasia. Moreover, there seems to be a logical contradiction. If a decision whether to discontinue sustaining a comatose patient is 'a judgement made in the face of a life still present',[68] is one not acting still within covenants 'of life with life'?[69]

It is not our duty to 'carry on our medical efforts to save life until the issue is taken out of our hands', but it is rather our duty to 'carry on our ministry of care and comfort and keeping-company with the dying until but only until *that* issue is taken out of our hands.'[70] What Ramsey seems to have overlooked is that ethics of covenant would have only benefited if it included such an immensely important part of keeping company and attending to the dying as prayer, which can be given and received not only consciously but on a subconscious level as well. But this would have meant going deeper theologically, which was not the plan for the author of *The Patient as Person*.

III. Tristram Engelhardt and the Ethics of Asceticism

1. Back to the Future

One of my friends characterized *The Foundations of Christian Bioethics* as 'tough'. This is the word he uses to describe a challenge. The book will be treated as such by many, or will be laughed at. Whatever the response, Tristram Engelhardt has launched a new framework for modern bioethics that is likely to find more opponents

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[67] *PP*, 163.
[68] See footnote 56.
[69] *PP*, xii.
[70] Ibid, 161.

than supporters. As Stanley Hauerwas puts it, he 'has thrown down a challenge to secular bioethics'.[71] I shall attempt to extend this account and argue that Engelhardt offers a new Christian bioethics, much more powerful than what was running under this title before. For a better understanding of this one has to keep in mind the author's conversion and baptism into Orthodox Christianity on April 6, 1991. *The Foundations of Christian Bioethics* is a result of a long journey, which started in 1986 with the ethics for 'moral strangers' and developed into the one of 'moral friends'.

The Foundations of Christian Bioethics is a mirror of *The Patient as Person.* Ramsey focused his skills on the medical side of bioethics, Engelhardt pursued the spiritual side. To paraphrase one of the metaphors in *The Foundations,* they are two lungs of bioethics. If Ramsey's engagement in technological aspects almost converted Christian ethics into medical ethics, Engelhardt attempts to restore the balance working out a content-full theological basis. This is called for by our new era. Since Ramsey wrote our global society has become increasingly liberal, which unfortunately appears to be tantamount to post-Christian. It is no longer possible to rely on the commonly recognized remnants of Christianity, as Ramsey once did. The alternative is 'to join a religion and be careful to choose the right one'.[72] Engelhardt was and still is much criticised and mocked upon for this blunt proclamation. If Ramsey was largely read as a common denominator, Engelhardt seems to be saddled with a 'sectarian' stigma. Both are misinterpreted, the first because of his insufficient theology and tricky prose, the second due to misrepresentation and resulting misperception. What *The Foundations* actually offer is a logical continuation of the line brilliantly maintained by Stanley Hauerwas.[73] It is precisely about finding a proper *locus* for Christian bioethics.

a) From a Liberal to a Libertarian Cosmopolitanism

In the first chapter of his new book Engelhardt suggests that a major cultural shift from a libertarian cosmopolitan moral understanding to a liberal one has taken place in modernity and marked all spheres of human life, including bioethics.

One of the core features of the libertarian type of cosmopolitanism is the distinction it makes between society – 'the space afforded in civil society for persons

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[71] *FCB*, dust-cover.

[72] H. T. Engelhardt, Jr., *The Foundations of Bioethics* (New York: Oxford University Press, 2nd ed., 1996), xi [hereafter abbreviated *FB*].

[73] Part of which argues for the place for church and moral community in bioethics. See, for example: Stanley Hauerwas, 'Salvation and Health: Why Medicine Needs the Church' in *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church* (Notre Dame, Indiana: University of Notre Dame Press, 1986), 63-83.

and communities of diverse moral commitments to meet and interact' – and community – 'the highly morally constituted space of particular moral communities'.[74] In other words, in Engelhardt's corrected vision society should consist of and be shaped by communities understood as moral congregations. On the contrary, modern liberal society appears to be a new moral community absorbing and universalising diverse congregations. Whilst striving to give the impression of being free, it actually imposes an ideology of its own, promoting and securing certain social values like liberty and equality as well as moral ones such as self-determination and public consensus. In other words a libertarian type of society would be characterised by inclusiveness, whereas a liberal one would be characterised by substitution.

Outlining the difference, Engelhardt astutely remarks that 'moral content is purchased at the price of universality' and vice versa.[75] This being the case, the question arises whether any balance is to be found at all; or whether we are bound to travel in circles heading either towards content and losing in universality or the other way round. I am inclined to think that the vast majority of Engelhardt's readers would be ready to accuse him of calling humankind to embark on content and abandon universality. Such readers will run the risk of too simple an interpretation.

For a deeper understanding of the author's argument for divorcing libertarian and liberal concepts (which might look very much alike to the untrained eye) it is worth going into each one in more detail.

According to Engelhardt, the liberal ethos has the following characteristics:

- consent as a value;
- moral imperialism;
- liberation from 'the dead hand of tradition'.[76]

The libertarian ethos, on the other hand, is described by:

- consent as a necessity;
- moral freedom;
- space for particular bonds.

While the notion of consent appears to be a mutual characteristic, Engelhardt clearly shows that the meaning ascribed to it is dramatically different. If the centrality of the principle of permission in a libertarian society is but 'the only source available for

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[74] *FCB*, 44.
[75] H. T. Engelhardt, Jr., *Morality, Universality, and Particularity: Rethinking the Bioethics of Community*, http://www.cityu.edu.hk/rcpm/proceedings/tristram.html (5 February 2002), Abstract.
[76] *FCB*, 43.

secular authority'[77], in a liberal perspective it becomes a value to be publicly recognized. Instead of allowance for co-existing moral principles, the liberal ethos forces both implicitly and explicitly a ranking system of its own, thus depriving individuals of a free moral choice. Hence, the liberal ethos is essentially neither truly liberal nor cosmopolitan. It claims to provide a new content-rich moral vision eschewing any particular bonds to the past that will not exactly fit in. The libertarian ethos, on the contrary, 'can compass divergent moral visions, moral communities, and fragments of moral communities'. It offers 'a *modus vivendi* with moral force but without content for a world marked by a plurality of moral visions'.[78] And in this sense it is truly liberating and cosmopolitan. It might preserve that very balance which keeps one on solid grounds between conservatism and empty universality.

All of this is not to be taken as giving the status of an ideal model to a libertarian society. Engelhardt is convinced that for 'the traditional Christian' it would still feel uncomfortable. But at least 'it affirms a space for traditional Christians to live as they wish'.[79] Not only for them, but for any specific moral community, as we have seen from the argument. It is just that the lapse into liberalism jeopardizes primarily the traditional moral framework.[80]

On the other hand, there is still something in Engelhardt's model of a 'peaceful libertarian society' that makes one feel uneasy. Hauerwas puts his finger on the problem in his essay on the second edition of *The Foundations of Bioethics*: 'I am not at all convinced that the peaceable society Engelhardt desires exists, can exist, or, if it did exist, would be peaceable'.[81] Though Hauerwas acknowledges he does not have an alternative, at least on the theoretical level, he claims that 'our task, as Christians, is not to offer such theoretical alternatives, but rather to be an alternative'.[82] It is another question what this actually involves. And if it means that 'we must be willing, if we are to live morally in this life, to let others suffer for our principles',[83] the peace of Hauerwas might appear no less violent than he claims Engelhardt's to be. This is a profound dilemma that so far admits of no resolution.

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[77] Ibid, 41.
[78] *FCB*, 42.
[79] Ibid.
[80] This danger does not face 'the various Christianities' (as Engelhardt calls them) in the same way. The reasons will be dealt with in later sections of this essay.
[81] *WW*, 118. Although the argument Hauerwas examines appears in a work which precedes *The Foundations of Christian Bioethics,* it still seems to be relevant. The important point here is that the second edition of *The Foundations of Bioethics* has been written by already Orthodox Engelhardt.
[82] Ibid, 122.
[83] Stanley Hauerwas, 'Love's Not All You Need' in *Vision and Virtue: Essays in Christian Ethical Reflection* (Notre Dame, Indiana: Fides/Claretian, 1974), 121.

b) From Secular to Christian Bioethics

There is a crucial difference between liberal and libertarian moral frameworks in the kinds of ethics and bioethics they produce. While the former tries to accommodate secular bioethics which leaves no place for any form of distinct Christian bioethics, the latter, 'by default'[84] gives the only chance for the survival of both secular and Christian bioethics.

Engelhardt's metaphor of 'moral strangers' opens the door to the ethical world of post-modernity. Largely developed in his previous works, it is only summarized in *The Foundations of Christian Bioethics*, but remains essential to the overall mapping of the author's thought.

> The terms "moral stranger" and "morally strange" are not used to indicate an opaque other whose actions are not understandable. As already indicated, the terms are employed to identify circumstances in which persons do not share either (1) common moral premises, rules of evidence, and rules of inference so that their moral controversies can be settled by sound rational argument, or (2) a common understanding of who is in moral authority, so that their moral controversies can be settled by a definitive ruling or process.[85]

It is precisely these two conditions described by Engelhardt that define modern societies and shape the ethics they practise. In a highly individualized world such as ours where diversity is so salient and bitter, morality has no common or, as Engelhardt puts it, 'canonical' grounds except for those of consent or permission.

Historically, there were two ways of resolving moral controversies. The older one was based on a recognized moral authority of the 'grand narrative' and the whole tradition thereafter. This was then exchanged for discursive reason in an attempt to give a better foundation for public discourse, as the old one seemed to have lost its relevance. Engelhardt draws out three 'fundamental Western experiences',[86] which led step by step to the formation of secular bioethics: the split of Western Christendom after the Reformation into various 'Christianities and Christendoms',[87] the vain effort of the Enlightenment to overcome the resulting diversity by discursive reason alone and, finally, post-modernity facing the same problem of separation and alienation. Humankind seems to have made a journey that has come full circle.

Engelhardt argues that a common background morality accepted by all is a modern myth. It is used to construct the type of secular bioethics of the liberal

[84] *FCB*, 40.
[85] Footnote 6 of Chapter 1 in *FCB*, 46.
[86] *FCB*, 38.
[87] Ibid.

cosmopolitan kind, which is dead before it is alive because the basis it claims to have does not exist. The mistake is made when despite celebrating cultural diversity, one does not recognize its counterpart, moral diversity, and tries to dispose of it either by denying the significance of moral disagreements or condemning those who disagree instead of looking into the ways of reconciliation. In other words those who, in addition to cultural differences, do not share a common morality would not be able to start a sound rational argument and those who have similar moralities would have different moral theories, namely different scales of moral values and principles that would be argument-stoppers. Once realized, it reveals the falsehood of liberal secular bioethics and the 'moral unanimity' in the decisions of current bioethics commissions turns simply into 'a political construction'.[88] The work of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research is commonly taken to prove the existence of a common background morality, whereas in fact gathering people with similar moralities and only theoretical disagreements determined its apparent success. Engelhardt suggests it would have been another story

> had the Commission when discussing fetal research included a representative from the pope of Rome, an atheist feminist, a fundamentalist Baptist, a Maoist communist, a libertarian, and an advocate of unhindered choice in the matter of abortions.[89]

He goes on to say that resolving moral controversies by engaging discursive reason is impossible not only for those who do not share common morality, but on a deeper level it appears to be impossible even for those who seem to adhere to the same morality and only differ in theoretical reconstructions of it or in particular accounts of it:

> If one begins with different rankings of important human values or right-making conditions, one will not share a common morality. If one does not have the same moral premises as well as rules of evidence and inference, one will not be able to resolve moral controversies by sound rational argument.[90]

Given the failure of discursive reason as a binding principle and consequently the fall of the secular bioethics grounded in it, one is left with a choice between a new libertarian type of secular bioethics based on consent and a Christian bioethics.

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[88] *FCB*, 28.
[89] Ibid, 30.
[90] Ibid, 32.

One would have expected Engelhardt to hold on to this choice. He does not. The question further examined is whether there is any difference left. Engelhardt regards the 'Christianness' of modern Christian bioethics as problematic.[91]

Starting from the nineteenth century onwards, Roman Catholic theological reflection developed an extended medical-ethical tradition. However, after Vatican II it was profoundly shaken by an attempt to change the church tradition and 'ways of doing theology, including bioethics'.[92] As Engelhardt aptly remarks, the Christian bioethics which emerged in the 1960s 'did not so much produce manuals or guides for the perplexed physician, nurse, or believer, as it did reports of theological perplexity'.[93] The later crisis of Christian ethics in general and bioethics in particular has its roots in the crisis of moral theology and, one step removed, in the crisis of self-identity encountered by Western Christianity. Engelhardt quotes Pope John Paul II lamenting 'the loss of faith' and 'a decline or obscuring of the moral sense'.[94] All of which seems to have been caused in the first place by dropping 'major elements of the Christian faith – the miracles, the Virgin Birth, the bodily resurrection of Christ, the expectation of Christ's return, the reality of eternal damnation'.[95] Christianity has become so diverse in itself that it can hardly provide a satisfactory moral guidance even for those within its boundaries. As has been indicated earlier, different moral theories cannot by definition imply common morality. Consequently, this kind of inner contradiction brings the Christian moral framework too close to the secular one. In abandoning beliefs that were once the substance of Christianity, the uniqueness is lost and some kind of middle ground acquired. The conclusion Engelhardt draws is that the battle for a distinct Christian bioethics has in the end been lost. One might wonder whether such a distinct bioethics was ever needed. After all, if we stick to the libertarian type of society and to the libertarian ethics of consent does it really make a difference to distinguish between secular and Christian moral frameworks? Engelhardt's answer is 'yes'. In the world literally structured according to 'which individuals have agreed to do what with whom',[96] the hunger for content, value and meaning is ever increasing. Christianity might have been the 'bread' so longed for, but it appears that in its contemporary form it

[91] See: ibid, 14.
[92] *FCB*, 9.
[93] Ibid.
[94] See: Ibid, 10.
[95] Engelhardt quotes Steve Bruce: *FCB*, 11. See also footnote 45 of Chapter I, p. 55.
[96] *FCB*, 39.

is more likely to starve itself. The danger then is to give in to the new liberal moral imperialism. With regard to bioethics it would be to adopt a new religion of human rights and personal autonomy and to forgo defeated concepts of the sacredness of life and covenant as the foundation of relationships.

The 'what to do' question remains. What Engelhardt suggests is radical in the deepest sense of the word. He emphasizes that 'Christian bioethics depends on knowing what Christianity is and which Christianity should guide'.[97] He claims it should be traditional Christianity, the one of the first millennium. Its bioethics is grounded 'within an ascetic and liturgical theology confident that its inspiration is from the same Spirit Who inspired the Scriptures and directed the Apostles'.[98] Traditional Christianity as Engelhardt perceives it has no flavour of sectarianism or narrow-mindedness. On the contrary, it entails no impediments for

> the reader from whatever religion to enter into the religious experience alive in the texts, prayers, moral understandings, and spiritual concerns of Christianity's first millennium. Some might regard these texts and usages as only historical relics. Others might consider a call to return to the sources primarily as an invitation to study and reorient an academically framed theology. Here the invitation is to enter into a lifeworld that knows without doubt that St. Basil the Great (329-379), St. John Chrysostom (334-407), St. Gregory the Theologian (329-390) and St. Simeon the New Theologian (949-1022) are constant, living companions.[99]

In other words, Christian bioethics introduced in *The Foundations* is universal in a brand new, illuminating sense. It is not bought at the price of content, but introduces the content that once had and still possesses the potential for universality. Engelhardt's Orthodoxy is not, as Stephen N. Williams thinks, either to be accepted or rejected.[100] It is to be seriously reflected upon. In a certain sense what one can find in the book can be shocking and at times deeply offensive to secular morality. If it feels the same with regard to 'other Christian religions', the reason would probably be in the fact that their morality has come to coincide with the secular one. And rather than accusing the author of fundamentalism, one would do better to ponder on the nature of contemporary liberalism. Being fundamental does not boil down to fanaticism. I would rather say that in his interpretation reason takes its place, namely as the human extension or reflection of God's wisdom. It is precisely the ranking that matters. *The Foundations* offers not a regressive process, but the way back to the future. It is a conversion of 'the process of

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[97] Ibid, xiii.
[98] *FCB*, xii.
[99] Ibid.
[100] Stephen N. Williams, 'A Stranger in A Land of Strangers: Englehart's Thesis Outlined', *E&M*, 81.

decision-making from harried perplexity into hopeful pilgrimage'.[101] So let the journey begin.

2. Suffering and Death: Reinforcing Their Christian Meaning

a) The Cosmic Narrative Versus Tolerance and Acceptance

Since I am especially interested in the problem of euthanasia, it is a regrettable but a necessary limitation that I will discuss in more detail only the framework offered for end-of-life decision-making, bracketing out questions regarding procreation and healthcare policy despite their being naturally intertwined.

Engelhardt invites the reader to participate in the search for the 'enduring meaning' of human finitude. This meaning, he argues, 'must not be transient'.[102] The answers to the most profound metaphysical questions asked in the face of suffering and death are nowadays provided within the liberal cosmopolitan ethos. These answers, being rooted in the values of self-determination, liberation from the constraints of the past and self-fulfilment[103] fail to reach beyond the realm of immanence. They give no appropriate food to 'still the hunger for the transcendent'.[104] Moreover, this liberal cosmopolitan ethos virtually makes post-traditional Christianity an offer that cannot be refused. The central thing that contemporary Christianity seems to be able to offer unanimously, whatever denomination, is love for your neighbour. Leaving aside the fact that even this concept is interpreted differently, ranging from Ramsey's covenantal framework to Fletcher's situationalism, it has in itself no grounds for separating itself from the ethos of personal autonomy.

> Christians who love their neighbors should in terms of this liberal cosmopolitan reorientation encourage choices concerning death that support the values, freedom, and dignity of their neighbors.[105]

Engelhardt suggests there are only two ways for post-traditional Christian bioethics to be compatible with secular liberalism: tolerance and acceptance. If tolerance presupposes allowing others to engage in something which one considers to be wrong (e.g. physician-assisted suicide and active voluntary euthanasia), acceptance entails acknowledging certain practices to be right for others, but not for oneself. The final step will be to question the impossibility of granting oneself the liberty one has already

[101] Ibid, 78.
[102] *FCB*, 309.
[103] See: ibid, 312.
[104] Ibid, 313.
[105] Ibid, 312.

granted others. To escape from this moral trap, it is instructive to return to that well-forgotten 'grand narrative' of sin, forgiveness and salvation.

There are fewer and fewer Christians who would recognize themselves as bearers of the consequences of Adam's sin largely due to misinterpretation of the process. Adam's sin is not hereditary, it is not stamped on the forehead of every newborn. It is rather an echo of that first distortion of the human nature, which affects each of us in particular and all our lives in general. Here is the metaphorical allusion Engelhardt uses to facilitate a proper understanding of the meaning of the original sin:

> Like a father who in sin contracts a disease he passes to his children without his children inheriting the guilt, all inherit the consequences of Adam's sin, though not his guilt...Adam and Eve infected our nature with sinful inclinations, suffering and death. Each of us then further compounds the problem by adding the consequences of our own voluntary pride and rebellion.[106]

In this light suffering *per se* should be avoided whenever possible and when it cannot be avoided it should be borne with patience and faith in God, who says:

> Come unto me, all ye that labour and are heavy laden, and I will give you rest. Take my yoke upon you, and learn of me; for I am meek and lowly in heart: and ye shall find rest unto your souls. For my yoke is easy, and my burden is light. (Mt. 11. 28-30)

It is only in Christ and with Christ that the meaning of suffering and death is truly revealed and transformed, revealed where it seems to be meaningless and transformed into a great gift where it seems nothing but a punishment. Christ through his own suffering and death on the Cross has deprived these categories of an absolute meaning. His victory is the one that can be and should be followed by Christians. Outside the Christian context the only liberty left is to eliminate suffering altogether and at least control death. With Christ's resurrection neither of this is needed. Even the most painful concern about suffering of the innocent children is answered. Engelhardt gives an example of the babies in Bethlehem slaughtered by Herod. He shows that they 'in dying because of Christ were saved as martyrs for Christ', [107] and affirms redemption through baptism for all innocent children. The point Engelhardt makes explains why the Orthodox Church maintains the tradition of infant baptism. Given the fact that children, though innocent themselves, are affected by the consequences of Adam's sin and often suffer from their parents' misbehaviour, only baptism in Christ can transform this dreadful state of affairs and bring great glory out of pure misery. To summarize, suffering and death are always the consequences of sin in one way or another and may

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[106] *FCB*, 314.
[107] Ibid, 316. See also footnote 32 of Chapter 6.

be avoided where possible. But this should not become an aim in itself, because through Christ we are given the promise of eternal life, a breakthrough from the immanent to the transcendent. Unavoidable suffering can have a therapeutic role that helps to 'abandon pride, and purge the heart from the passions that control us'.[108]

The narrative so powerfully presented to the reader is cosmic in the sense that it is open to everybody and embraces everything while at the same time remaining 'a particular story involving particular people and their relationship with a transcendent but personal God'.[109] This narrative reminds us of a universal potential for participation: 'And other sheep I have, which are not of this fold: them also I must bring, and they shall hear my voice; and there shall be one fold, and one shepherd' (Jn 10. 16).

b) From Sin to Holiness Through Asceticism

Christian bioethics rooted in the cosmic narrative opens a new horizon for medical decision-making. As Christians, we are not only called to be good, but to ascend to holiness. This assumption takes one a significant step further than justice, canons of loyalty, the sanctity of life or steadfast love. The promise of eternal life is the opportunity for every person to become holy. This is what salvation is about. Tragically, the true meaning of holiness is often misunderstood. A saint is not somebody who is totally free of sin, but the one who has 'fought the good fight' either against the consequences of original sin or against his own sins and won. The ideas of sin and holiness properly understood put all that we do in the right perspective. They give a new solid ground for Christian bioethics. As Engelhardt defines it, 'beyond the sphere of morality as the domain of responsible action, there is holiness which we will not be able to endure unless our hearts are purged from defilement'.[110]

Indeed, attempts to ground Christian bioethics solely in covenant, sacredness of life or in love for the neighbour, 'aim somewhat short of the mark'.[111] All of these would do very well even outside a Christian context, in Judaism or Islam, for that matter. As has been previously shown, covenant-centred ethics is limited to the capacity of the parties involved. Ramsey acknowledges that there comes a time when a person is beyond our care.[112] And it is then that active euthanasia becomes morally justified. Love for the neighbour is no better guide, unless properly understood:

[108] *FCB*, 315.
[109] Ibid, 313.
[110] Ibid, 326.
[111] An expression Engelhardt uses frequently. See, for example, *FCB*, 316.
[112] See: *PP*, 162.

Fletcher's interpretation leads to treating an embryo in certain circumstances as 'an aggressor or unwelcome invader' and claims this treatment to be in the name of love.[113] Finally, the concept of life as a sacred gift takes us only so far with the notion of sacredness as well as with the metaphor of gift. Any precious possession we have this side of death is limited to the 'best before date', which does not however deprive it of intrinsic value. Totally wrong as it may be 'to throw the gift back in the face of the giver',[114] there are no reasons not to return an enriched and fruitful life exercised in good and faithful stewardship as the offering of the talents in the parable. From this point of view, one might have strong doubts that 'our living is an obligation'.[115] Every trusteeship is finite by definition and the foundation Christian bioethics really needs is the one that would not be subject to expiry. In summary,

> this is not to deny a place in Christian bioethics for moral rules, commandments, or precepts: properly understood, they indicate real boundaries beyond which one will go very wrong rather than enter into union with God. But they cannot be systematized in terms of conceptual foundations.[116]

An attempt to systematize moral commandments into a basis for an ethical framework taken by numerous theologians starting with Ramsey, though no doubt sincerely well-intended, has paradoxically resulted in 'going beyond the boundaries'.

Engelhardt offers the foundation of holiness, the ultimate goal of pursuing the Kingdom of Heaven. The means is a fight against sin, the method is asceticism, 'the discipline of becoming watchful so as not to be mastered by passions, temptations, or even particular goals and projects, in order to turn fully to God'.[117] The approach in making moral decisions is therapeutic[118] and the focus is on spiritual concerns.

c) Spiritual Dimensions in Medical Decision-Making

Traditionally, three conditions are central for Christian moral decision-making in the context of death: intention, motivation and the nature of causal involvement in human death. The right intention should be to avoid a spiritual threat, the right motivation should be to submit humbly to God's will, and these two additionally should

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[113] See the case study in Joseph Fletcher, *Situation Ethics* (London: SCM, 1966), 37-9 [hereafter abbreviated *SE*].
[114] *EEL*, 146.
[115] Stanley Hauerwas, 'Rational Suicide and Reasons for Living' in *OMM*, 674.
[116] *FCB*, 209.
[117] Ibid, 317.
[118] It seems to break the concept of 'three approaches' in *SE*, 17.

be secured by spiritual therapy in cases of involuntary homicide.[119] In other words, the framework suggested is not juridical (i.e. judging the guilt and/or its degree), but spiritually therapeutic (i.e. curing the effects of even unintentional involvement in evil).

Engelhardt outlines the following points to abide by in medical decision-making:

- the direct will to kill the innocent is voluntary and unmitigated homicide in the full sense; this applies to all kinds of euthanasia (voluntary, non-voluntary and involuntary) and physician-assisted suicide in their contemporary meaning: the evil of these actions is not done away either with consent or with pleadings of the subject;
- killing in a certain capacity (e.g. as an executioner) or under certain circumstances (e.g. in self-defence or in a just war) can be spiritually harmful and therefore should not be exempt from spiritual therapy;
- medicine can and should be used both to cure disease and postpone death provided appropriate spiritual circumspection is present;
- medical intervention should not be
  a) so demanding or absorbing as to harm spiritual life (Engelhardt includes here heart transplants, complex repetitive surgery and long-term artificial hydration and ventilation);
  b) so little as to refuse adequate remedies that God has allowed medicine to develop (insulin for diabetes and antibiotics for sub-acute bacterial endocarditis) or to choose only between elimination of suffering and pain and a premature death;
- pain control should be aimed not only at comfort but also at aiding in preparation for death; analgesia provided should not be in itself sufficient to bring about death;
- extraordinary means to sustain life may be appropriately used to win extra time for repentance and spiritual preparation for death.[120]

Interestingly, in setting the 'upper' and the 'lower' levels for medical intervention, Engelhardt is, in fact, distinguishing between ordinary and extraordinary treatments. While stating that both kinds (if imposing an excessive spiritual burden) not only may be but should be withdrawn or withheld,[121] he nevertheless stresses the imperative for a hermit to avoid travelling to a dialysis center to treat renal failure by using 'should', at

[119] *FCB*, 324.
[120] My summary of spiritual guidelines given by Engelhardt in *FCB*, 326-7.
[121] This statement will be more closely examined in the section dealing with medicine as an idol.

the same time regarding the failure to use insulin and antibiotics as 'usually sinful'.[122] It would seem to me that whilst obviously making room for certain exceptions in the obligatory usage of ordinary treatments, Engelhardt would have been more consistent not to ascribe categorical prohibition to the extraordinary ones. In the context of winning extra time for repentance and adequate preparation for death, would it not be morally justified in some cases to go ahead with heart transplants or even repetitive surgery?

All this taken into consideration, three instances in medical-ethical decision-making seem to beg further clarification. How does one apply Engelhardt's framework in the case of 'voiceless patients', as Ramsey would have called them, namely 'defective newborns', those in deep and prolonged coma and in PVS?

Since it is traditionally a custom in the Orthodox church for children to start their confessions at the age of seven, it presupposes that younger children would not really need a preparation to death in any way similar to that required of adults. As has been mentioned earlier, suffering of the innocent is transformed in the union with Christ. The only crucial thing then would be to win time for baptism. But once a baby is baptised, it could probably be quite fitting to determine the further course of action by engaging a medical indications policy, as has been thoroughly worked out and carefully presented by Ramsey in his *Ethics at the Edges of Life.*[123] He has argued that Dr Zachary, using strictly medical criteria for judging the eligibility of *spina bifida* babies for an operation is standing on morally safe ground. What this doctor tries to do 'is not to add years to their lives but to add life to their years'.[124] Neither taking the years of a baby's life nor judging the quality of the possible period of life is taking place.

With comatose and PVS patients it is rather difficult to see a direct spiritual threat in medical treatments. Although Engelhardt lists long-term artificial hydration and ventilation as spiritually harmful, it could probably be more so for the family and caregivers rather than for the patient himself. Therefore, Engelhardt advises the use of advance directives 'not only to avoid medical interventions likely to be useless or spiritually burdensome, but also positively to ensure appropriate spiritual guidance as death approaches.'[125]In this respect it is worth pointing out that not only a proxy decision-maker but also a person's spiritual father should be indicated in the advance directive. Moreover, a proxy decision-maker may not need to be a 'usually expected

[122] *FCB*, 326.
[123] *EEL*, 181-8.
[124] Quoted by Ramsey in *EEL*, 184.
[125] *FCB*, 322.

family member', but someone 'most likely to aid in one's pursuit of the kingdom of heaven'.[126] The big question though is whether anything can be done in the case where the patient for whatever reasons might have not had a chance for repentance and proper preparation to death before coma or PVS happened. Our inability to communicate with such patients does not necessarily mean God's inability. And if this is the case would there not be at least some sense in continuing to sustain them for a longer period of time if only to keep praying for them, or even *with* them? I think there is an indication for it in the words of the Bible quoted by John Breck:

> I slept, but my heart was awake (Song of Sol. 5:2)
> If I ascend to heaven, Thou art there; if I make my bed in Sheol, Thou art there! (Ps 138/139:8)[127]

d) Suicide

Before proceeding with further examination of euthanasia-related issues, it is worth clarifying the question of suicide. Most of the ethos of euthanasia that has currently emerged is largely due to confusion about what is to be counted as suicide and what is not. For example, Christian theologian Paul Badham builds his argument in favour of euthanasia on Biblical authority, saying that 'it is not actually the case that the Bible condemns self-slaughter and Biblical suicides are characteristically regarded as honourable'.[128] Engelhardt rightly traces the degree to which the confusion has sometimes amounted to the theory of Christ's death on the cross 'interpreted as a kind of suicide'.[129]

To put matters straight, one has to bear in mind the distinction, made by the early Church, between suicide and martyrdom. This distinction is, precisely, 'between those acts through which one turns to oneself or others versus those through which one turns oneself first and foremost ascetically to God'.[130] Engelhardt gives examples from the lives of the saints such as St Martinian (422), the Martyr Nicodemus (eighteenth century) and Fr Augustinus the Russian (1965). The first and the last have to do mainly with threatening one's life to preserve chastity and the second one with exposure to

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[126] Ibid, 322-3.
[127] John Breck, *The Sacred Gift of Life: Orthodox Christianity and Bioethics* (Crestwood, New York: St Vladimir's Seminary Press, 1998), 231.
[128] See the article 'Sources of Authority in Christian Ethics' by Paul Badham in DISKUS *WebEdition, Diskus,* 4 (1) (1996), http://www.uni-marburg.de/religionswissenschaft/journal/diskus/badham.html (26 April 2004), Abstract [hereafter abbreviated SACE].
[129] *FCB*, 327. See also footnote 60 of Chapter 6, 347.
[130] Ibid, 330.

martyrdom. I reproduce here the whole story of Fr Augustinus, as it appears to be both summative and closest to the reader in time.

> [Augustinus was called Antonius until he was clothed.] As he told me [i.e. Alexander Golitzin[131]], he was at a monastery that was almost entirely composed of old men and they despatched him to serve as an aide for an employee of the monastery in the fishery, for the monastery was supported by the fishery. One day, the daughter of the employee came and told her father that there was an urgent task at home, so she sat in his place to help [the novice]. Temptation overcame the poor woman and without thinking she threw herself on the novice with sinful intentions. At that moment, Antonius lost control because the event happened so suddenly. He made the sign of the Cross and said, "My Christ, it is better to drown than to sin" and flung himself from the shore into the deep river! But the good God, viewing the great heroism of the holy youth, who acted like a new St Martinianos in order to preserve his virtue, held his head up above the water without even getting wet. As he told me, "Although I flung myself headfirst, I did not understand how I found myself standing above the water without even getting my clothes wet!"
> At that moment, he also felt an internal peace and an inexpressible sweetness, which made every sinful thought and every carnal urge disappear, which had been provoked beforehand by the impious gestures of the girl. When the girl saw Antonius standing upright, she began to weep in repentance because of her sin and also because she was moved by the great miracle itself.[132]

Let me justify this prolonged quotation by pointing out a certain dangerous tendency it might provoke. What Engelhardt apparently tries to underline is that proper understanding is essential to avoid mistaken suicidal judgements. Clear enough as the distinction might be between suicide and readiness for martyrdom, namely to be prepared to confess one's faith up to the point of dying for it, the difference is not as obvious in the case of preserving chastity as Engelhardt presents it. There is the possibility that the justification he gives might be taken too far through an assumption that as long as one entrusts oneself to God and makes the sign of the cross it is not sinful to choose death. Besides, there would surely be other ways to reject the sinful temptation in a situation similar to the one in which St Augustinus found himself. To get the message of this story right one has to look at it from a slightly different angle, which Engelhardt is well aware of when he says that traditional Christian bioethics is not legalistic but therapeutic in its nature. The way St Augustinus acted is not determined by the circumstances he found himself in but rather by what kind of person he was at the time when these circumstances occurred. Had he been older and wiser, had he already acquired the spiritual experience necessary to resist the temptation in less radical ways, he would have no doubt used it. But he was only a novice and the decision

[131] For the source of original quotation see: ibid, footnote 68 of Chapter 6, 347.
[132] *FCB*, 329.

he took was due to the unexpected pressure, when the only thing he could have known for sure was that he did not want to sin. Hence what he did was in a way a plea for God's help. It was as if he had said: 'My Christ, this is the only way I see of escaping from the spiritual threat that I am now facing, see me through this'. And he was heard. The story is not as much about what St Augustinus did or did not do as it is about who St Augustinus was. It does not tell us what to do but what to be.

There are certainly cases where some safeguard is needed in order to tell whether one is turning oneself 'first and foremost ascetically to God' or acting to the contrary. Engelhardt seems to be aware of this slippery slope when he cautiously remarks that 'the boundaries of what is allowable will at times be unclear and will require spiritual discernment'.[133] This brings us to the question of moral authority and the way it is seen and exercised in traditional Christianity. According to Engelhardt, this authority belongs to the spiritual father. I would add also that an original safeguard is to be found in Jesus' answer to the tempter: 'Thou shalt not tempt the Lord thy God' (Mt. 4.7).

Not to underestimate the definition Engelhardt gives, but rather to enforce it, I would suggest that the distinction with regard to death will be between placing all hope first and foremost in oneself or others or abandoning all hope whatsoever, versus always having hope in God, even if hope in oneself or others fails. The former disposition is most likely to lead to death by suicide, the latter will lead to a good Christian death. In these terms the suicide of Judas Iscariot is often interpreted as a result of the sin of despair, which is losing hope in God.

e) Against Medical Idolatry

Having established firmly that 'traditional Christianity is fundamentally opposed to physician-assisted suicide and euthanasia'[134] in a form they have taken within a liberal cosmopolitan ethos, one is still left with a puzzle regarding Engelhardt's unconditional demand that spiritually harmful medical interventions should be withdrawn or withheld. This kind of imperative could be very much welcomed by the proponents of the culture Engelhardt so explicitly distances himself from. It will be

[133] *FCB*, 330.
[134] Ibid, 331.

inevitably defined as passive euthanasia and may lead to, as James Rachels has shown, formation of 'a moral doctrine that may well be indefensible'.[135]

To restore the consistency of the argument one has to return to the basis of traditional moral decision-making. As has been indicated earlier, the grounds taken for certain allowances or prohibitions are rooted in the pursuit of the Kingdom of Heaven and primarily focused on balancing spiritual costs and avoiding spiritual threats rather than in the values of autonomy and self-determination. Hence euthanasia, active and passive alike, physician-assisted suicide or any other form of 'death with dignity' in secular liberal terms would be alien to traditional Christian bioethics. As Engelhardt suggests, terminology should be sorted out. Describing sins in terms that usually identify virtues is the worst case scenario.[136] It has to do with the good intentions with which the road to hell is paved.

Traditional Christianity sets its face against medical idolatry. Neither physician nor the art of medical science as a whole should take the place of God in our lives. In Engelhardt's words, nowadays 'few individuals will sell all that they have to pursue eternal salvation, while many will sell all they have to secure a few more years of life'.[137] Given the promise of resurrection, this earthly life is not all one has. Therefore physical or even psychological health is not the prime target to aim at. The target is spiritual health or holiness. Amongst other things asceticism implies resistance to overwhelming goals and projects in this life. St Basil the Great warns against 'whatever requires an undue amount of thought or trouble or involves a large expenditure of effort and causes our whole life to revolve, as it were, around solicitude for the flesh'.[138] To draw on this warning, any kind of medical treatment that falls under the qualification given is eligible for withholding or withdrawing. One has to keep in mind that 'paradoxically, the technological imperative to use all available resources to save life can lead to the temptation to take life'.[139] The paradox applies both to extraordinary and ordinary means. Engelhardt acknowledges that in some cases even eating may become burdensome for a particular patient. In consequence, it is often more significant how something is done medically rather than what is or is not done. Neither action nor omission should proximately lead to death independently of the disease process. In omissions, for example, one should act with the right intention of avoiding spiritual

[135] James Rachels, 'Active and Passive Euthanasia' in Tom L. Beauchamp and Terry P. Pinkard (eds.), *Ethics and Public Policy* (Englewood Cliffs: Prentice-Hall Inc., 1983), 317.
[136] See: *FCB*, 332.
[137] Ibid, 317.
[138] Quoted by Engelhardt in *FCB*, 317.
[139] Ibid, 319.

injury, not bringing about an earlier demise. However, Engelhardt takes this argument further in admitting the difficulty in drawing a clear-cut line. Withholding or withdrawing treatment and pain relief may in some instances and in some sense be the cause of death as much as any of the pathological processes. To facilitate clarification, Engelhardt engages a distinction developed in the classical account of causation in the law by Hart and Honoré.[140] He emphasizes that the difference is somewhat like the one of secular or non-traditional bioethics between intentionally causing death and allowing to die. However, 'the traditional Christian approach does not fully fit within this classification: it focuses primarily (albeit not exclusively) on intention and the avoidance of proximate causal involvement in the death of a human'.[141] The latter condition appears quite puzzling until explained in more detail. As an illustration, Engelhardt argues, *inter alia*, the incompatibility of being a priest and being a surgeon. This obviously echoes the statement that even killing the guilty or involuntary killing can harm our souls and thus requires spiritual therapy. The following grounds are given:

> Also, out of appreciation for the holiness of the altar, priests should generally avoid involvement in surgery as a profession, not just because of its bloody character, but because of the risk of being proximately causally involved in the death of a patient. It is not appropriate for the one who presides over the bloodless sacrifice of the Eucharist to have bloody hands.[142]

Let me point out that presenting this statement without a comment, Engelhardt runs the danger of rendering inappropriate the whole life of a contemporary Russian saint, Archbishop Luka (Valentin Voino-Yasenetsky), one of the best surgeons of the twentieth century, whose *Studies in Purulent Surgery* won a Stalin Prize, First Class, in 1946 and is still among the essentials in surgery.[143] The existence of contradictions such as this may seem to make Engelhardt guilty of being 'too ready simply to report what the early Fathers taught without exploring the inner rationale of their teaching'.[144] Or, to be more precise, being guilty of generalizing a particular experience, turning it into something legalistic, which he himself strictly opposes. Nevertheless, the remedy for

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[140] Ibid, 319-320. See also footnote 41 of Chapter 6, 345. Cf H. L. A. Hart and Tony Honore , *Causation in the Law*, second edition (Oxford: Clarendon Press, 1985).
[141] *FCB*, 320.
[142] Ibid, 322.
[143] For an account of life of Archbishop Luka in English see, for example: Volodymyr Zemytan, 'Light in the Darkness', *The Day,* wysiwyg://49/http://www.day.kiev.ua/DIGEST/2001/21/culture/cul6.html (28 February).
[144] Gilbert Meilaender, 'A Texian-Constantinopolitan Bioethic', *First Things* 107, November 2000, 58-62, http://www.firstthings.com/ftissues/ft0011/reviews/meilaender.htm (5 February 2002) [hereafter abbreviated TCB].

this is not the conclusion, which Gilbert Meilaender[145] reaches too easily, that the Fathers were simply mistaken and Engelhardt carries their mistakes on.

Let me reverse methodologically the pattern I used in discussing the abstract from the life of St Augustinus. There I attempted to present Engelhardt's example in a way that would avoid deriving a general statement from a particular experience. The assumption about the incompatibility of being a priest and a practising surgeon needs to be accompanied by a particular experience to sound less imperative and less general. Here is a dream that Archbishop Luka had, described in his autobiography:

> The altar in a small empty church is lit up. Next to the altar there is a tomb of a saint against the wall with a heavy wooden cover on it. A naked corpse lies on a wide piece of wood upon the communion table. Medical students and doctors are gathered round, smoking and listening to my lecture on dissection. All of a sudden a heavy bang makes me shiver and turn around. The cover has fallen off the tomb and the saint is sitting up and looking at me with a silent reproach. [my translation][146]

This dream is very interesting as it shows that St Luka was aware of the possible 'inappropriateness' suggested by Engelhardt. Partially it was due to the respect the church has traditionally paid to the body of a dead person, which dissection seems to withdraw in a certain sense. Partially the dream might have reflected the guilt that the surgeon had for the deaths of some of his patients during operations. One of his assistants wrote later that for Dr Yasenetsky each death was a personal tragedy deeply felt. He was obviously struggling to reconcile his spiritual vocation and professional commitment. And he repented for the inevitable 'proximate causal involvement' in death, which the latter presupposed. St Luka, like St Augustinus, prayed that whatever he was doing in attending both to souls and bodies might be put right by God. Reconciliation was granted when once during his prayers he heard: 'This do not confess.'[147] It is, again, first and foremost a story of being.

The beauty of the spiritual heritage in traditional Christianity lies in its richness, which is not a set of contradictory imperatives as it may seem if approached legalistically, but a mutually fulfilling experience of particular persons passed down to us through generations. Consequently, the much misunderstood concept of moral authority in traditional Christianity (or in present-day Orthodoxy, for that matter) is not substantially about imposing an absolute vision of what is morally right or wrong *per*

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[145] TCB, 61.
[146] Quoted by T. I. Grekova in: Т. И. Грекова, 'О вере и неверии людей науки'/'Belief and Disbelief of Scholars', http://www.MEDLINE.ru/medhistory/medarticles/overe.shtml (6 March 2002) [hereafter abbreviated BDS] [hereafter all Russian language sources in my translation].
[147] BDS.

se, but rather about the ability to 'discern the spirits'. In this framework, the role of the spiritual father is not so much in assigning penitence, but in 'feeling the way' to holiness for a particular person here and now.

IV. Conclusion

Deeply rooted Christian disapproval of taking a person's life has been challenged in the second half of the twentieth century by the unbelievable technological progress in medicine. It took quite an effort for theologians to produce a viable anti-euthanasia argument. In the rise of bioethics as such and particularly Christian bioethics in the 1960s an attempt to draw a clear distinction between 'euthanasiac acts' and 'a good death' unfortunately failed. Even Paul Ramsey's highly inquisitive and at times over-sophisticated concept ended up being caught in an acknowledgment of exceptional cases for an active termination of one's life. Other Christian writings on the subject turned out to be even more vulnerable to criticism. Neither love for the neighbour nor the sacredness of human life nor the divine giftedness of it could have provided a secure foundation to condemn the administration of a lethal injection, let alone the passive forms of terminating the patients' lives. Christian bioethics started to lose its face and began to be equated with a secular one. Indeed, the confidence that Paul Ramsey once had about the in-built Christianity of medical ethics, has later led some Christian theologians not only to believe that it is 'entirely legitimate for a Christian to look at these moral problems through the same eyes as the secular moralist', but even to argue that 'Christians ought to feel uneasy in any situation where their moral values differ from those of a caring, thoughtful and well-informed atheist'.[148] This worrisome tendency was captured by Stanley Hauerwas, who has powerfully turned theological-ethical discourse from theoretical casuistry to practical wisdom. Rather than trying to advance the precision of definitions or to give exhaustive guidance on moral matters he urged Christians to remember how to live as such. Hauerwas' work increasingly showed that the ambiguity of Christian bioethics largely stemmed from the fact that it was desperately trying to address the wrong issues. As Christians we should not seek to explain or eliminate all evil and suffering, but to learn how to respond to it in a Christian way: to live it out rather than cast it out. Instead of joining in the competition of theodicies, Hauerwas invited both moral theologians and bioethicists to bring out the Christians in themselves more distinctively, i.e. to explore how to be with suffering and

[148] SACE.

evil rather than what to do with them. Paraphrasing Michael J. Buckley, it suddenly dawned on the academic world of moral theology, with much help from Hauerwas, that the problem with evil is that it is not a problem.[149] A revelation of this sort, I reckon, was timely indeed, given the growth of different evils in modern society accompanied by much spiritual decline. It was a great contribution, taking Christian bioethics a huge stride forward in its development by bringing back what used to be a living tradition in the past. From being a purely intellectual enterprise this fairly new branch of moral theology acquired the stance of spiritual challenge. This challenge is further reinforced by Hugo Tristram Engelhardt Jr. In the *Foundations of Christian Bioethics* he managed to find a new cornerstone to build upon. Holiness as the ultimate vocation of every human being is so profound and at the same time so much forgotten that it comes as a new breath into the lungs of bioethical discourse. Unlike the idea of covenant, it is open-ended all through this earthly life, less exposed to misinterpretations than the idea of love, and much broader than the notion of gift. However, as has already been pointed out, while Engelhardt succeeds in strengthening the Christian rejection of active euthanasia, some of the guidelines he sets out can look peculiarly similar to what would be often called passive euthanasia. This creates an unpleasant ambiguity, which renders the whole framework wanting. The main reason for this, in my view, is that the therapeutic approach to bioethical issues is not and will hardly ever be completely susceptible to any definitions, even if they are presented as 'spiritual dimensions in medical decision-making'. The ethics of asceticism cannot be truly fulfilled as an academic framework, only as a way of life.

[149] Michael J. Buckley, S.J., *At the Origins of Modern Atheism* (New Haven: Yale University Press, 1987), 13.

CHAPTER III

A RUSSIAN ORTHODOX APPROACH TO EUTHANASIA: TOWARDS A CLEARER PERSPECTIVE

I. Introduction

In the second chapter of my dissertation I attempted to show how Western Christian bioethics has been transformed in the course of its development over a period of approximately thirty years, starting with the works of Paul Ramsey and currently reoriented by Tristram Engelhardt. With the idea of holiness as the ultimate aim of human existence Engelhardt performs a breakthrough, eliminating for Christian bioethics the danger of either conscious or unconscious advocacy for active euthanasia. The problem though is that he goes further and in a vigorous attempt to dismiss the understanding of medicine as a purpose in itself or regarding it as an idol seems to lose the thin balance and lapse into justifying a kind of passive euthanasia in the form of withholding or withdrawing 'spiritually burdensome' treatments. Having set its face against active euthanasia, Christian bioethics should search for ways of explaining how one is supposed to tell a really good Christian death from passive euthanasia. This painful dilemma, which sometimes leads to describing the problem as admitting of no solution, is exposed more than anywhere else in Russian law and practice. The current state of affairs in Russian society in general and in medicine and law in particular with regard to the question of euthanasia is paradoxical. While Russia has a law that explicitly prohibits euthanasia, public opinion polls recently reveal an astonishingly high percentage of proponents.[150] Moreover, according to an unspoken presumption, a passive form of this procedure is currently practised by Russian doctors.[151] This kind of collision appears to have two major reasons: progressing secularisation and a very low level of legal knowledge in the society.

Naturally, in a country with over a millennium's history of Orthodox tradition, the church is bound to respond to this overwhelming contemporary concern. The Church-Public Council on Bioethics Under the Moscow Patriarchate was established in

[150] According to a poll conducted by RPOMR (РОМИР: Российское Общественное Мнение и Исследование рынка/Russian Public Opinion & Market Research) in 2000, 20. 4 % of the participants consider euthanasia to be justified in the majority of cases and 18. 7 % believe it to be justified always, http://www.nns.ru/analytdoc/romopr135.html (12 May 2002).

[151] Маргарита Леонидова, 'Смерть по-доброму или по-божески', *Невское время* № 66 (2526), 11 апреля 2001 г./Margarita Leonidova, 'A Good Death or a Godly Death', *Nevskoe Vremya,* No. 66 (2526), 11 April 2001 http://www.nvrem.dux.ru/2001/arts/nevrem-2526-art-13.html (12 May 2002).

1998 with a membership including clergy and lay people: doctors, lawyers, and philosophers. Its research materials and prepared documents were actively consulted during the work on the *Foundations of the Social Concept of the Russian Orthodox Church* at the Jubilee Bishops' Council of the Russian Orthodox Church 13-16 August 2000.

On the academic side, Irina Siluyanova pioneered in systematizing bioethical knowledge in the light of Orthodox Christianity in her now well-known books *Ethics of Cure: Modern Medicine and Orthodoxy* and *Person and Illness.* She has a doctorate in philosophy and is currently the head of Bioethics Department at the Russian State Medical University. Since the *Foundations of the Social Concept* were adopted between the two editions of *Ethics of Cure* and the author is a Vice-Chairperson of the Church-Public Council, Siluyanova in a certain way represents Russian Christian bioethics 'in development'.

I shall present the full text of the *Statement of the Church-Public Council on Bioethics under Moscow Patriarchate Concerning Current Tendencies to Legalize Euthanasia in Russia* and the section of the *Foundations of the Social Concept of the Russian Orthodox Church,* which relates to the problem. I shall then move on to explore the writings of Siluyanova in the light of these two documents and conclude by drawing some parallels with Engelhardt's account that was discussed in the second chapter.

II. Adopting Western Practice: Peculiarities of Russian Healthcare

Undertakings which the Western world has pioneered are eagerly repeated in the East. Medicine is no exception. Informed consent and the value of autonomy are now as much Russian realities. Being taken and transferred as they are, these concepts adjust themselves often in the most unexpected and even skewed manner. Immersed into a different culture, often artificially placed right on the ruins of the previous alien structures they sometimes reveal a dark side.

The former Soviet healthcare system had two major characteristics that were officially approved and legally recognized, namely providing the right of every Soviet citizen to free medical services and the absolute duty of every Soviet doctor to always preserve health and save life. As a result, under the Soviet system even the idea of discussing euthanasia simply could not have been possible. Apart from the imperative and an absolute aim to preserve life, the pattern of a doctor-patient relationship that was adopted, automatically excluded any open conversations on the matter. One of the major

traits of the Soviet totalitarian paternalism was the concept of the 'sacred lie': 'In our medicine in general and in Soviet medicine in particular this question – whether to inform the patient about the likely death – has always had and *still has* [italics added] a negative answer'.[152] And this negative attitude, as the quotation shows, exists in spite of the Article 31 of the *Foundations of the Healthcare Law of the Russian Federation* that states the right of the patient to know the diagnosis and prognosis of their illness and to have access to their medical history.[153] Unfortunately, the majority of doctors and practically all the patients 'have no idea about the Foundations'.[154]

Nevertheless, new biomedical technologies and the change in mentality of the former Soviet people caused by Western influence, forced the medical profession to deal with problems they would have never come across within the old set up. Many among the older generation of doctors still struggle to solve them in general as well as at a personal level. Something that can be described as 'half-truth' or 'version' has taken the place of the former 'sacred lie'. It is believed now that 'the doctor-patient relationship should not have a fixed standard, neither a blunt truth-telling nor total disinformation is justified'.[155] Slowly the Russian healthcare profession moves towards answering the question of 'how to tell' rather than 'what to tell'. However, the bias is still, by and large, towards the doctor's decision, not the patient's. And many 'old school' specialists would be 'quite happy that nobody is aware of the existence of this law.'[156] In other words, if one does not insist on having the information, the chances are one would receive none.

Another sign of the emergence of a new mentality is represented by two articles that incorporate the concept of informed consent.

Article 32 in Section XI says that 'informed voluntary consent of a person is the necessary pre-condition of a medical intervention'.[157] This confirms the freedom of every individual with regard to starting the treatment and choosing its form. Another matter is that the theory is corrupted by the absence of choice in practice. The strongest

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[152] Л. А. Лещинский, *Деонтология в терапевтической практике* (Москва: Медицина, 1989 г.)/L.A. Leshinskij, *Deontology in the Therapeutic Practice* (Moscow: Medicine, 1989), 99.

[153] *Основы законодательства Российской Федерации об охране здоровья граждан* (Москва: Грант, 2000г.)/*Foundations of the Healthcare Law of the Russian Federation* (Moscow: Grant, 2000), 25 [hereafter abbreviated *FHL*].

[154] Валерий Чисов и Софья Дарьялова (Московский онкологический институт им. П.А. Герцена Министерства здравоохранения РФ), 'Проблема врачебной тайны в онкологии', *Медицинская газета*, № 68, 12 сентября 2001 г./ Valerij Chisov and Sophia Daryalova (Moscow Research Institute of Oncology named after P.A. Hertzen, Ministry of Health of the Russian Federation), 'Problems of Truth-Telling in Oncology', *Meditzinskaya gazeta*, № 68, 12 September 2001, http://medgazeta.rusmedserv.com/ (12 May 2002) [hereafter abbreviated PTTO].

[155] Ibid.

[156] PTTO.

[157] *FHL*, 26.

monopoly is held in oncology and brain surgery. Having only one special neurosurgical hospital and two institutions specializing in oncology, all of them ridiculously corrupt due to the general disastrous situation in healthcare and high demand for their services, one can hardly enjoy the right secured by the law.

Article 33 in the same section states a person's right 'to withhold or to withdraw medical intervention'.[158] Following Western practice, according to this article doctors are under an obligation to inform the patient about the possible consequences and ensure that the patient's decision is properly documented and signed. The decision can be taken not only by the patient himself but also by his 'legal representative'. The whole idea of a legal right of a patient to refuse treatment was so alien to the principles of Soviet medicine that Russian doctors still find it difficult to accept. 'How can a doctor accept a patient's refusal of the treatment that would save his life?' asks Professor Sophia Daryalova.[159] Despite all the sympathy post-Soviet society has to the values of human rights, and much eagerness in copying Western schemes, the older generation in the medical profession would still strongly object to any kind of 'stepping back' in the fight for health and life. Within the Soviet healthcare system there was an unspoken presumption that the only victory is a life saved by all means and at all costs available. Any failure was automatically condemned. This has probably been one of the reasons for the Association of Russian Doctors declaring passive euthanasia unacceptable.[160] It must be said though that younger doctors are much less sensitive in that respect and the majority of medical students do not have any objections to euthanasia. 49% of the doctors aged between 21 and 30 answered the question 'Do you consider euthanasia permissible?' answered either 'Yes, if that is the patient's wish', or 'In special circumstances'.[161]

Here one must remember that in Russia there is a great deal of confusion about what should be understood by euthanasia. And this is to be expected when the law contradicts itself. Article 45, Section VIII reads:

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[158] *FHL*, 26.
[159] PTTO.
[160] Ирина Силуянова, *Этика врачевания: современная медицина и православие* (Москва: Издательство Московского подворья Свято-Троицкой Сергиевой Лавры, изд. 2-ое, 2001г.)/Irina V. Siluyanova, *Ethics of Cure: Modern Medicine and Orthodoxy* (Moscow: Publishing House of Troitze-Sergieva Lavra, 2nd ed. 2001), 41 [hereafter abbreviated *EC*].
[161] С. В. Быкова, Б. Г. Юдин, Л. В. Ясная, 'Эвтаназия: мнения врачей': Юдин Б. Г. (ред.), *Биоэтика: принципы, правила, проблемы* (Москва: Эдиториал УРСС, 1998г.)/ S.V. Bykova, B.G. Yudin and L.V. Yasnaya, 'Euthanasia as Seen by Doctors' in Yudin B.G. (ed.), *Bioethics: Rules, Principles and Problems* (Moscow: Editorial URSS, 1998), 367 [hereafter abbreviated *BRPP*].

> It is prohibited for the staff of medical institutions to perform euthanasia, i.e. to follow the patient's request to quicken his death by carrying out any acts or employing any means, including stopping artificial life-sustaining procedures.[162]

With a virtually non-existent bioethical theory the reality of everyday practice is in danger of going beyond the moral boundaries. Therefore, the articles of the *Healthcare Law* were so to speak not 'putting the cart before the horse', but appeared as an attempt to respond to the already existing practices and tendencies. Nevertheless, with a situation where euthanasia in one or another instance is approved by almost half of the younger generation of doctors (21-30 years old)[163] and 39. 1% of the population in general,[164] in spite of being officially illegal, ways other than just a legal prohibition need to be found to ensure high moral standards and appropriate ethical decisions. However strong is the conviction of the Minister of Health of the Russian Federation Yurij Shevchenko that 'a law similar to the one adopted in the Netherlands will never exist in Russia, because our society, tradition and culture would never allow that',[165] more than these notions is needed to secure such confidence. Our culture is becoming more and more secular, seventy-odd years of communism have forced tradition to retreat to geographically and intellectually remote parts of our society which has already started to live by the same liberal values of freedom, equality and personal autonomy of which the Dutch are so proud. Therefore it is extremely interesting to hear Shevchenko saying that euthanasia 'is a grave sin and we cannot allow it to happen'.[166] Fortunately, statements like this open the door for Christian bioethics into the public discourse. If the Minister of Health operates with a notion of sin, there is a need for an explanation why he would regard euthanasia as such and what are the ways for it not to happen in Russia. Here is one such explanation.

III. The Rise of Christian Bioethics in Russia

1. Statement of the Church-Public Council on Bioethics under the Moscow Patriarchate Concerning Current Tendencies in Euthanasia Legislation in Russia[167]

> The problem of euthanasia has emerged in our society out of "ideological pluralism", which presupposes the co-existence of different value systems,

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[162] *FHL*, 33.
[163] *BRPP*, 367.
[164] Percentage added up in the RPOMR public opinion poll.
[165] 'Шевченко против эвтаназии', *Известия*, 11 апреля 2001 г./ 'Shevchenko Against Euthanasia', *Izvestiya*, 11 April 2001, http://news.km.ru/news/view.asp?id=21B93615DD01407A847AD2_F3AB54B18A [hereafter abbreviated SAE].
[166] SAE.
[167] My translation.

including the one allowing killing and "a right to die". Proponents of euthanasia are convinced that this "right" should be embodied in law and provisions should be made for it to be exercised, using the resources of contemporary pharmacology and the healthcare system.

On this matter the Church-Public Council on Bioethics under the Moscow Patriarchate considers it necessary to make the following statement.

Acknowledging the value of life of each person created in the image and likeness of God, autonomy and dignity as unique personal characteristics, Orthodox clergy, academicians and doctors disapprove of any attempts to legalize euthanasia which, as an act of intentional taking of life of terminal patients, is a specific form of murder (when it is a doctor's or family's decision), suicide (when carried out upon the patient's request), or a combination of both. The Council is against euthanasia in any form on the ground that its practice will inevitably lead to:

a) medicine acquiring a criminal character and the healthcare system losing its credibility;
b) violation of the sanctity of life;
c) perverting the meaning of the medical profession and undermining the dignity of the doctor;
d) slowing down in the development of medical knowledge: resuscitation techniques, pain-relief, remedies for presently incurable illnesses, etc.;
e) increasing cynicism, nihilism and moral decline in society in general as a result of forgoing the commandment 'do not kill'.

A qualified doctor should know that a plea to accelerate death may come out of depression, which distorts the perception of reality. It is also important to bear in mind that freedom of choice and a right to change one's decisions is intrinsic to human nature.

Drawing on all of the above, the Council regards euthanasia as morally unacceptable and firmly objects to its legislation, which will integrate into the public conscience the possibility of a medical murder or suicide.

2. *Foundations of the Social Concept of the Russian Orthodox Church*[168]

XII. Problems of bioethics

XII. 1. The rapid development of biomedical technologies, which have invaded the life of modern man from birth to death, and the impossibility of responding to the ensuing ethical challenges within traditional medical ethics have caused serious concern in society. The attempts of human beings to put themselves in the place of God by changing and «improving» His creation at their will may bring to humanity new burdens and suffering. The development of biomedical technologies has outstripped by far the awareness of possible spiritual-moral and social consequences of their uncontrolled application. This cannot but cause a profound pastoral concern in the Church. In formulating her attitude to the problems of bioethics so widely debated in the world today, especially those involved in the direct impact on the human being, the Church proceeds from the ideas of life based on the Divine Revelation. It asserts life as a precious gift of God. It also asserts the inalienable freedom and God-like dignity of man called

[168] The translation is taken from the official website of the Russian Orthodox Church at: http://www.russian-orthodox-church.org.ru/sd00e.htm (9 May 2002) [hereafter abbreviated *FSC*]. I have substituted here the word 'Foundations' for 'Bases'.

to be «the prize of the high calling of God in Jesus Christ» (Phil. 3:14), to be as perfect as the Heavenly Father (Mt. 5:48) and to be deified, that is, to become partaker in the Divine nature (2 Pet. 1:4).

XII. 8. The practice of the removal of human organs suitable for transplantation and the development of intensive care therapy has posed the problem of the verification of the moment of death. Earlier the criterion for it was the irreversible cessation of breathing and blood circulation. Thanks to the improvement of intensive care technologies, however, these vital functions can be artificially supported for a long time. Death is thus turned into dying dependent on the doctor's decision, which places a qualitatively new responsibility on contemporary medicine.

Holy Scriptures treat death as the separation of the soul from the body (Ps. 146:4; Lk. 12:20). Thus it is possible to speak about a continuing life as long as an organism functions as a whole. The prolongation of life by artificial means, in which in fact only some organs continue to function, cannot be viewed as obligatory and in any case desirable task of medicine. Attempts to delay death will sometimes prolong a patient's agony, thus depriving him of the right to «honourable and peaceful» death,[169] for which the Orthodox Christian solicits the Lord during the Liturgy. When intensive care becomes impossible, its place should be taken by palliative aid (anaesthetisation, nursing and social and psychological support) and pastoral care. All this is aimed to ensure the true humane end of life couched in mercy and love.

The Orthodox understanding of an honourable death includes preparation for the mortal end, which is considered to be a spiritually significant stage in the life of a person. A patient surrounded with Christian care can experience in the last days of his life on earth a grace-giving change brought about by a new reflection on his journey and penitent anticipation of eternity. For the relatives of a dying man and for medical workers, an opportunity to nurse him becomes an opportunity to serve the Lord Himself. For according to the Saviour's word, «inasmuch as ye have done it unto one of the least of these my brethren, ye have done it to me» (Mt. 25:40). The attempt to conceal from a patient the information about the gravity of his condition under the pretext of preserving his spiritual comfort often deprives a dying person of an opportunity to be consciously prepared for death and to find spiritual consolation in participation in the Sacraments of the Church. It also darkens his relations with relatives and doctors with distrust.

Death throes cannot be always effectively alleviated with anaesthetics. Aware of this, the Church in these cases turns to God with the prayer: «Give Thy servant dispensation from this unendurable suffering and its bitter infirmities and give him consolation, O Soul of the righteous» (Service Book. Prayer for the Long Suffering). The Lord alone is the Master of life and death (1 Sam. 2:6). «In his hand is the soul of every living thing, and the breath of all mankind» (Job 12:10). Therefore, the Church, while remaining faithful to God's commandment «thou shalt not kill» (Ex. 20:13), cannot recognise as morally acceptable the widely-spread attempts to legalise the so-called euthanasia, that is, the deliberate destruction of hopelessly ill patients (also by their own will). The request of a patient to speed up his death is sometimes conditioned by depression preventing him from assessing his condition correctly. Legalised euthanasia would lead to the devaluation of the dignity and the corruption of the professional duty of the

[169] A more accurate translation of the full phrase is: 'A Christian end to our life, painless, unashamed and peaceful, ... let us ask'.

doctor called to preserve rather than end life. «The right to death» can easily become a threat to the life of patients whose treatment is hampered by lack of funds.
Therefore, euthanasia is a form of homicide or suicide, depending on whether a patient participates in it or not. If he does, euthanasia comes under the canons whereby both the deliberate suicide and assistance in it are viewed as a grave sin. A perpetrator of calculated suicide, who «did it out of human resentment or other incident of faintheartedness» shall not be granted Christian burial or liturgical commemoration (Timothy of Alexandria, Canon 14). If a suicide is committed «out of mind», that is, in a fit of a mental disease, the church prayer for the perpetrator is allowed after the case is investigated by the ruling bishop. At the same time, it should be remembered that more often than not the blame for a suicide lies also with the people around the perpetrator who proved incapable of effective compassion and mercy. Together with St. Paul the Church calls us: «Bear one another's burdens, and so fulfil the law of Christ» (Gal. 6:2).

3. An Unfolding Parachute: The Works of Irina Siluyanova

Irina Siluyanova appears to be the first Russian specialist who has seriously studied biomedical ethics in the light of the tradition of the Orthodox Church. Whereas in the West, those 'who disagree with a sinful way of life have long ago won the opportunity to protest',[170] in Russia the voice of Christian bioethics is only starting to be heard. Metaphorically speaking, Siluyanova does a job of unfolding the Christian parachute. She tries to rediscover Orthodox Christianity for bioethics in Russia in a way Engelhardt attempts to do it in the West. This parachute will hopefully help slow society's descent down the 'slippery slope' of euthanasia.

a) The 'Physics' and 'Metaphysics' of Death

Like many of her colleagues in the West, Siluyanova approaches the problem of euthanasia within a Christian understanding of life and death. She starts with the reminder that Christianity has given people an understanding of the value of human life. This understanding is based on the idea that life comes 'as a gift, in communion with that Life which gives and sustains the life of the world.'[171] Death also has a meaning that transcends its physical aspect.

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[170] Протоиерей Димитрий (Смирнов), 'Попытка раскрыть парашют': Ирина Силуянова, *Человек и болезнь* (Москва: Издательство Сретенского монастыря, изд. 2-ое, 2001г.)/Revd. Dmitrij Smirnov, 'Unfolding Parachute', Preface to Irina Siluyanova, *Person and Illness* (Moscow: Publishing House of Sretensky Monastery, 2nd ed. 2001), 4 [hereafter abbreviated *PI*].
[171] *EC*, 95.

> New medical criteria of human death – 'brain death' – and new social approaches to the death of an individual – 'the right to die' – are not pure medical issues. The "physics" of death as it is directly links with its "metaphysics", i.e. its moral interpretation.[172]

Religion and morality form the flesh of 'metaphysics', whereas 'physics' has to do with medicine. Through the centuries of human history these two co-existed within the boundaries of Christian civilization. In the past death was certified by the respiratory standstill and cardiac arrest, echoing the Christian understanding of heart activity and breathing as the basics of human life. Therefore the first attempts at reviving human beings were aimed at the renewal of blood circulation and respiratory function.

In the nineteenth century the stormy development of medical technologies called for a more precise certifying of death. Later the investigation of revival methods was accompanied by detailed studies of the process of dying. The Russian doctor V. Negovsky[173] has divided it into five stages: 1) pre-agony, 2) terminal pause, 3) agony, 4) clinical death, 5) biological death. This distinction between clinical death (the reversible stage of dying) and biological death (the irreversible stage) has given grounds for reanimatology* as a science, which studies the mechanisms of dying and revival. The term 'reanimatology' was introduced into scientific usage by Negovsky at the International Congress of Trauma Specialists in Budapest (1961).

Unbelievable success in resuscitation technologies in the 1960-70s would be ascribed by many to overcoming the traditional criteria of human death and reaching a new level in death certification – brain death. This breakthrough, remarks Siluyanova, increases the ethical tension. Do resuscitation procedures always work to the patient's benefit? Needless to say, in a number of cases modern resuscitation techniques allow the saving of a person's life, but they may as readily turn into the 'prolonging of dying'. Commenting on this, Siluyanova quotes M. Heidegger, who sees 'technical' as a human plan in a broad sense, which eventually forces one to undertake certain actions whether one wishes to do so or not. In medical practice it means that modern medicine, equipped with resuscitation devices, can no longer refuse to apply them, thus 'converting its patients into victims.'[174] In this situation life support exists on the verge of prolonging of death, the latter 'having a technological potential of up to ten years.' Siluyanova alludes to Professor B. Yudin, who, speaking of patients in coma, aptly defines the

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[172] *EC*, 225.

[173] About V. Negovsky see: Каталог *Золотая книга России. Год 2000* (Москва: АСМО-пресс, 2000г.)/Catalogue *The Golden Book of Russia. Year 2000* (Moscow: ASMO-press, 2000), http://analytics.ex.ru/cgi-bin/txtnscr.pl?node=578&txt=463&lang=2&sh=1 (10 May 2002).

* This is a literal translation from Russian, the English equivalent is 'resuscitation technology'.

[174] *EC*, 228.

period between 'certainly alive' and 'certainly dead' as an 'area of uncertainty'. This area

> finds itself literally outside the Bible commandments. The sixth commandment 'thou shalt not kill' *(Ex. 20. 13)* simply 'doesn't work' here, because in terms of traditional morality this is an area of inevitable killing, or of rejecting 'life supporting treatment.' In attempting to take moral and legal responsibilities from the involuntary performers of the 'area's will' – the doctors, society turns to the principle of euthanasia – intentional, pain-free killing of terminally ill people. [175]

b) The Last Right of the Last Illness or Death as a Stage in Life

Current medicine has a wide range of research works on the psychology of terminally ill patients at its disposal. Among the most detailed and profound Siluyanova points out the works of Dr E. Kübler-Ross, who together with her colleagues developed a concept of 'death as a stage of growth'. Schematically it could be divided into five stages: 1) denial ('It can't be me, it's not cancer'), 2) protest ('Why me?'), 3) request for delay ('Not right now, just a little later'), 4) depression ('Yes, it is me dying'), 5) acceptance ('Let it be'). Remarkably enough, the final stage is often characterized by statements similar to the following: 'I had a richer and more rewarding life for the last three months than ever before.' And these are the words of people who were very well off before their illness. Siluyanova sees this position as 'a result of realising the existential drama of human life, which is the unfolding of the real meaning of life and death only "in the face of death".'[176] She shows just how close psychological studies in healthcare can sometimes be to the Christian attitude towards dying. 'Orthodoxy does not accept the principle of 'telling lies'. In the Christian perception of the world death is a way to eternity. Terminal illness is an utterly significant event, preparation for dying and coming to terms with death. It is an opportunity to repent, to reflect, to intensify one's spiritual labours and prayer, it is a transformation of the soul into a certain quality of being, which is recorded in eternity.'[177] This echoes the statement in *Foundations of the Social Concept of the Russian Orthodox Church*:

> The attempt to conceal from a patient the information about the gravity of his condition under the pretext of preserving his spiritual comfort often deprives a dying person of an opportunity to be consciously prepared for death and to find spiritual consolation in participation in the Sacraments of the Church. It also darkens his relations with relatives and doctors with distrust.[178]

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[175] *EC*, 229-230.
[176] Ibid, 250.
[177] Ibid, 251.
[178] *FSC*.

The right of a patient to his own point of view, the right of personal freedom and self-determination are only fully exercised in conjunction with the right of the last illness.

c) On Euthanasia

According to Siluyanova the recent progress in medicine and the drastic change in values and moral priorities towards centralizing the idea of 'human rights' within modern civilization are the two major factors that have contributed to the spreading of euthanasia as a new medical method of solving the problem of suffering.

Since 1996 surveys regularly conducted at the Russian State Medical University show that 80-90% of students are in favour of legalizing euthanasia and ready to perform it for their patients. In spring 2000 an opinion poll launched in the Moscow Medical Academy named after I.M. Sechenov revealed that 78.4% of its students were for and only 18.9% against euthanasia; the rest were unsure about their position. [179] The following year 256 medical students participated in a survey conducted by the Department of Bioethics at RSMU. Although 70.7% identify themselves as Orthodox believers, 39.8% agree with euthanasia and 37.7% do not.[180] Commenting on the data, Siluyanova sees the process of secularisation as one of the most important factors in the increasing percentage of euthanasia supporters. Another explanation she gives is the 'inability of the current educational system to satisfy the students' spiritual need'[181] by offering adequate courses in theology, philosophy, religious and cultural studies. It is vitally important, for example, to be aware of the different forms of euthanasia, and primarily to differentiate active and passive types. The results of the surveys, one might add, would have been perhaps quite different had the distinction been made clear.

Siluyanova defines active euthanasia as the 'lethal injection of a medication performed by a doctor.' [182] In the case of passive euthanasia 'medical help is stopped in order to quicken the natural death.'[183] Further Siluyanova describes three subdivisions: voluntary, non-voluntary and involuntary. The first one is performed upon request of a competent patient, the second can take place upon the decision of the family or trustees,

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[179] *PI*, 93.

[180] Ирина Силуянова, ' *"КОНВЕНЦИЯ О ПРАВАХ ЧЕЛОВЕКА И БИОМЕДИЦИНЕ" СОВЕТА ЕВРОПЫ И "ОСНОВЫ СОЦИАЛЬНОЙ КОНЦЕПЦИИ" РУССКОЙ ПРАВОСЛАВНОЙ ЦЕРКВИ: СРАВНИТЕЛЬНЫЙ АНАЛИЗ'*/Irina Siluyanova, '*Convention on Human Rights and Biomedicine* of the Council of Europe and the *Foundations of the Social Concept of the Russian Orthodox Church:* Comparative Analysis', http://www.pravoslavie.ru/jurnal/society/socdoc.html (12 May 2002) [hereafter abbreviated CA].

[181] CA, http://www.pravoslavie.ru/jurnal/society/socdoc.html (12 May 2002).

[182] *EC*, 231.

[183] Ibid.

provided the patient is incompetent (i.e. incapable of making her own decisions) and, finally, the third one is carried out 'without the competent person's consent.'[184]

The crucial arguments in favour of voluntary euthanasia (active and passive alike) usually presented within the modern liberal context are compassion for the suffering and acceptance of the right of every person to determine the time of their own death. Offering death as a 'treatment' of pain is a supportive medical argument. Another reason for voluntary euthanasia is regarded as 'altruistic': a wish of a patient not to be a burden to family and friends. However, comments Siluyanova, in most cases this wish 'is determined not so much by the fact that the person does not want to continue living as by the fact that she must not continue, thus allowing the concern about the people around her to absorb the individual will to live.'[185] This commentary captures well the other side of an over-optimistic 'right to die with dignity.' The 'quality' or 'dignity' of death in the proposed meaning is to a great extent influenced by the 'quality' of life and, suggests Siluyanova, is often based on an 'egoistic motivation.'[186] Defending euthanasia can also have serious social consequences. Social approval of euthanasia logically ends up in getting rid of handicapped people, especially the newborn. Siluyanova reminds her readers of a well-known practice in Fascist Germany, where a special 'programme of euthanasia' was executed in 1938-39 and of an organisation called "Euthanasia", which in the 1930s in America tried to change the law and legalize the killing of mentally defective or physically handicapped people. If in the first half of the twentieth century the world rejected such ideas, today, warns Siluyanova, they are evolving again. Mercy for those patients who are 'hopeless' and justice with respect to their relatives or even to society in general, including insurance companies and various state institutions, are the two foundation stones laid by modern apologists of euthanasia. Nevertheless, to operate with Christian ideas of mercy and justice does not necessarily mean to be Christian. Siluyanova argues that to use these ideas in justifying euthanasia is 'one of the signs of sheer anti-Christianity as a form of spiritual imposture'.[187] The powers directly opposite to Christianity appropriate Christian ideas and values. What a crooked way of putting the two mutually excluding words together in a new term of 'mercy killing'! Can anybody help being tempted to accept euthanasia as a way not to become a burden and to exercise true care and love for one's nearest and dearest? However, reminds Siluyanova, such 'care' and 'love' would only be superficial, because the real

[184] *EC*, 232.
[185] Ibid, 233-4.
[186] Ibid.
[187] Ibid, 235.

'love for your nearest consists in the opportunity during the illness to take care of the one you love with patience and thus truly and directly to serve the Lord.'[188] Father George Chistyakov, a well-known Moscow priest, echoes this concern in stating that 'the problem is not in euthanasia as such and not even in the horror of pain that the dying people go through, but in our abandoning them, because we think we cannot help them'.[189] He calls us to learn not only how to think, but how to feel as Christians, that is, how to behave as such.

Summarizing, Siluyanova considers the conservative position to be 'simple and non-ambiguous.'[190] To define it, she quotes *Orthodoxy and Bioethics* by S. Harakas, where the author evaluates intentional killing of a dying patient as a particular instance of murder, if performed without a patient's awareness, or as suicide, if performed with a patient's approval. Siluyanova emphasises the fact that the conservative position is not confined to the Orthodox one, but also includes the opinion of specialists, which was once that of a majority. The negative response to the moral and legal possibility of euthanasia goes back to the Hippocratic Oath, which was adopted 'against the background of the absolute social acceptance of suicide in the cultures of Ancient Greece and Ancient Rome.'[191] According to Siluyanova, doctors have their own reasons to support the conservative point of view. These reasons emerge from medical practice:

- the history of medicine is familiar with the cases of 'spontaneous cure' of , for example, cancer;
- people with various disabilities are still able to maintain a lifestyle they are happy with;
- the acceptance of death as a variety of medical 'treatment' will inevitably limit the development of medicine itself, largely stimulated by the constant 'fight against death'.

IV. Conclusion

If Paul Ramsey in the 1960s started his bioethics assuming 'that a remnant of the Christian age remains',[192] Tristram Engelhardt has flavoured his argument with the

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[188] *EC*, 236.
[189] Протоиерей Георгий Чистяков, 'Умирание или эвтаназия'/Revd. George Chistyakov, 'Dying or Euthanasia', http://cmf.narod.ru/pubs/euth/euth3.html (10 May 2002).
[190] *EC*, 236.
[191] Ibid, 237.
[192] Quoted by Stanley Hauerwas in *WW*, 129.

bitter taste of 'a frankly post-traditional secularity'[193]through and through. Indeed, is Christianity no more, as Engelhardt claims?

Siluyanova argues that what is happening to humankind in our time does not indicate the end of the historical existence of Christianity, but rather reiterates the 'constantly returning' opposition of Life and Death, Christianity and Paganism. 'Christianity has never in its history been outside this opposition. The differences were only in the manner, acuteness and scale of it'.[194] Siluyanova has undertaken an extremely interesting and informative comparative analysis, which shows that the Foundations of the Social Concept of the Russian Orthodox Church are not only very close to the European *Convention on Human Rights and Biomedicine* and other major international legal documents, but have something substantial to contribute.[195]

True as it may be that 'Western Christendom has become secular',[196] the situation in Russia has the potential to escape irredeemable secularity. Now is the time to work hard for the day Ramsey has hoped would dawn 'when the dominant secular viewpoints on morality will be extended from the church of Jesus Christ'.[197] In the country where the Minister of Health in order to ban euthanasia legislation uses as the main argument the notion of sin and appeals to tradition, where the law prohibits 'mercy killing' and provides for the patient to have a voice in decisions about medical treatments, there is a unique opportunity for Christian bioethics to integrate into the public morality. The *Foundations of the Social Concept* being in agreement with the state law gives more power to the Russian Orthodox Church in opposing euthanasia. On the other hand, while Siluyanova considers the conservative position on euthanasia to be simple and non-ambiguous, in reality it is still far from absolute clarity. *The Statement of the Church-Public Council on Bioethics* and Article 45 of the *Foundations of the Healthcare Law* unanimously condemn euthanasia 'in any form'. At the same time the *Foundations of the Social Concept* make it clear that 'the prolongation of life by artificial means, in which in fact only some organs continue to function, cannot be viewed as obligatory and in any case a desirable task of medicine' and thus 'attempts to delay death will sometimes prolong a patient's agony, thus depriving him of the right to "honourable and peaceful" death, for which the Orthodox Christian solicit the Lord during the liturgy'.[198] In order for a Christian attitude to euthanasia to be viable some

[193] *FCB*, xiv.
[194] *PI*, 138.
[195] CA.
[196] *FCB*, 2.
[197] Quoted in *WW*, 130.
[198] *FSC*, 151.

guidelines are needed in judging when this deprivation begins, otherwise it runs the danger of condoning its passive form while setting its face against the active. These guidelines can be found in the framework developed by Engelhardt. In my view it can be that material which Orthodox Christian bioethics in Russia needs for completing the building on the foundation it already has.

CHAPTER IV
CASE STUDIES

I. Introduction

No theory can be fully appreciated without its application in practice. The previous chapters as well as the euthanasia debate in general would hold little importance if left on paper. The whole purpose of academic ethical studies is, or at least should be, to evaluate the manner of acting in real situations of decision-making at the end of life. Comparison of the concepts developed by Engelhardt and Ramsey creates a spiritual perspective within which one can operate and the definitions and distinctions set out the terms of operation. This is not to say though that ethical decisions are totally dependent on choosing the correct framework. Moral issues do not qualify for manuals. The framework one uses rather stems from the kind of person one is, not the other way round. This simple truth seemed to gain understanding with much difficulty, even with Hauerwas pushing it hard, until Engelhardt confronted the academic world with his "traditional Christianity" explicitly distinguished from "other Christian religions". Much as criticism is and will continue to be addressed to the *Foundations of Christian Bioethics* for its 'fundamentalism', Engelhardt to a large extent takes the philosophy of Hauerwas to its logical conclusion when he writes that 'one should join a religion and be careful to choose the right one'.[199] Taken literally it comes as an offence to those who fail to 'choose right', but it seems to me that a deeper implication of this phrase is an attempt to change the situation where 'Christian ethicists continue to leave the world as they found it'.[200] Metaphorically speaking, choosing a religion is precisely about deciding what kind of person one wants to be before engaging in action or refraining from it. Keeping this in mind I would like to discuss a number of cases, which have largely formed and recently kept the euthanasia debate high on the public agenda in the UK.

Looking closely at these cases contributes to the future of bioethical discourse on Russian soil. Whereas in Britain controversial medical end-of-life decisions have been taken through the judicial system for quite a time already, in Russia such practice

[199] *FB*, xi.
[200] *WW*, 137.

is virtually non-existent. But it is only a matter of time. Public hearings in the courts similar to those of Diane Pretty and Miss B are sooner or later to be expected. And since, unlike in the West, there are still only a few strong bioethical voices in the Russian academic world, the general public will be left only with the media interpretation of the cases. This is a really dangerous thing to happen. Apart from the manipulative character of the modern *vox populi,* the lack of expertise mass media displays (whether negligently or intentionally) inevitably leads to misplaced judgements. As I have already stressed in the third chapter, progressive secularization and a high level of legal ignorance in Russian society today create numerous opportunities for abuse of public opinion in terms of ethics and morality. British euthanasia-related cases receive an almost immediate ethical, moral and legal evaluation from prominent scholars, professional associations and the Church. These cases, of course, become known in Russia, but newspaper articles and TV programmes are about the only sources to provide the coverage. Naturally, they come out at best as one-sided stories, at worst as a bad misinterpretation of facts. Therefore, Russian Christian bioethics badly needs not only the knowledge of Western Christian academic works on euthanasia, but some competent analysis of related cases, so that when the case-wave reaches Russia, one would know what to make of it.

I shall start with the cases which in my view can be described as active euthanasia. The case of Dr Nigel Cox, one of the earlier trials of an English GP that stirred controversy over the issues of 'a good death', will be followed by an insight into the actions of the notorious Dr Harold Shipman. The latter, in my view, are among the best arguments against the legalization of euthanasia the world has ever encountered, and offer the most powerful support for John Keown's argument regarding the danger of the "slippery slope". The cases of Tony Bland and that of Ms B will close the section on the active form of euthanasia and I shall then turn to the case of Dr Leonard Arthur, which undoubtedly represents its passive form. The plight of Mrs Diane Pretty and the implications of her legal fight for the 'right to die' belong to the section on assisted suicide.

In the course of case examinations I shall use the information provided by four main types of sources: academic, legal, medical and the media. I shall try to establish whether my definition developed in the first chapter can be applied to each of the cases and if so to further determine the appropriate distinctions. I would like to emphasize here that the ultimate purpose of the analysis is not to judge the validity of particular

legal or medical decisions as such, since I have no expertise in those fields, but to unveil some of their moral and ethical implications.

II. Active Euthanasia

According to the definition in the first chapter euthanasia consists in medical staff intending the death of a patient. Therefore I consider the following four cases to qualify as euthanasia in general and as its active form in particular, although in various ways and with different distinctions.

1. Dr Nigel Cox

The story

70-year-old Lillian Boyes suffered from an acute rheumatoid arthritis, was bedridden and had a gastric ulcer and bedsores. According to the competent body of medical opinion her life expectancy was low. Mrs Boyes was in much pain, which did not seem to have responded to the medication prescribed by the doctor. Dr Nigel Cox, a consultant rheumatologist in the NHS hospital in Hampshire where Mrs Boyes was treated gave her an intravenous injection of two ampoules of potassium chloride[201] and she died in a few minutes. After the police investigation the Crown Prosecution Service took action and Dr Cox was convicted of attempted murder[202] by Winchester Crown Court on 18 September 1992. On 17 November the same year the General Medical Council reprimanded the consultant but did not suspend his registration.

Euthanasia or palliative care?

According to the evidence given by the doctor himself 'he had administered the lethal injection so as to relieve Mrs Boyes of the intractable and incurable pain she was suffering'.[203] Since pain-killers failed to perform that task, Dr Cox 'chose to relieve her

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[201] *EEPP*, 12.
[202] As to why it was not a conviction of murder see John Harris, 'Euthanasia and the Value of Life' in John Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge: Cambridge University Press, 1995), 20, footnote 3 [hereafter abbreviated *EE*].
[203] R. v. Cox, *Medical Law Review*, 1, Summer 1993, 232 [hereafter abbreviated *MLR*].

pain by ending her life'.[204] It might seem that the doctor was acting in total compliance with the so called doctrine of 'double effect', which is and has always been considered part of palliative care and thus has nothing to do with euthanasia. However, to equate what Dr Cox has done with palliative care is fundamentally wrong.

The substance used for the injection is of crucial importance. It is a medical fact that potassium chloride 'has no curative properties and is not used to relieve pain'.[205] Drugs such as potassium chloride or curare are poisons, not pain-killers and their 'primary action is to cause death'.[206] Plainly speaking, the injection would not alleviate pain, 'but instead stop Mrs Boyes' heart'.[207] Moreover, it is agreed that 'one ampoule would certainly kill'.[208] Two were given. John Harris has suggested that 'had Dr Cox administered a lethal dose of an opiate which also possessed analgesic properties he would probably never have been tried for attempted murder'.[209] This is a valuable observation, bearing in mind the two earlier trials of Drs John Bodkin Adams and David Moor, who administered fatal doses of diamorphine to their patients, and were both acquitted. The fact that they were able to walk free from a murder charge can probably be explained by the lack of consensus on the exact quantity of opiates to render the dose fatal.[210] However, it is crystal clear that this cannot in any way be applied to the case of Dr Cox. So much for the medical side of the problem.[211]

The only option?

Judge Ognall in directing the jury stated that '[i]t was plainly Dr Cox's duty to do all that was medically possible to alleviate her pain and suffering'.[212] One might have the impression that what Dr Cox did was at least partially justified on the grounds that intravenous potassium chloride was indeed 'all that was medically possible' given the circumstances of Mrs Boyes's condition. In other words, was it not, one might suggest, one of these rare cases where the only way to alleviate the patient's pain and

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[204] Ibid, 233.
[205] *EEPP*, 11.
[206] Robert G. Twycross, 'A Doctor's Dilemma' in *Euthanasia Booklet*, Chapter 5, http://www.cmf.org.uk/pubs/booklets/euth/dilemma.html (27 July 2002) [hereafter abbreviated *EB*].
[207] BBC Panorama Case Histories: End of Life Decisions, Case 2, http://news.bbc.co.uk/1/hi/audiovideo/programmes/panorama/1971527.stm (26 July 2002)
[208] *EEPP*, 11.
[209] *EE*, 7.
[210] Medical expertise in Shipman's report.
[211] As to the legal side, there is an interesting interpretation of the principle of 'double effect' contradicting that of Keown in R. v. Cox, *MLR*, 233. Curiously enough both Keown and the author(s) of the commentary refer to the case R. v. Moloney. For Keown's account of this case see *EEPP*, pp. 27, 29 and footnote 26 on p. 25.
[212] R. v. Cox, *MLR*, 233.

suffering was to kill the patient? However, even if such cases do exist, this was not the one. The commentary in *Medical Law Review* suggests that 'he could, presumably, have sedated Mrs Boyes without killing her'.[213] Likewise, Robert Twycross, who is one of the greatest authorities in palliative care in the UK, in his analysis of the case affirms that a lot more could have been done to ease Mrs Boyes's pain and suffering and gives an extensive medical evaluation of the possible patterns of treatment.[214] He warns that euthanasia 'would take the medical profession and society over a dividing line, which however thin it may become on rare occasions, they cross at their peril.'[215]

Summarizing, one has more than sufficient grounds to classify Dr Cox's actions as active (since it was an injection) euthanasia, and taking into consideration that Mrs Boyes 'repeatedly begged him to kill her', [216] the applicable distinction is 'voluntary'.

2. Dr Harold Shipman

Let not this name take the reader aback as ridiculously inappropriate to be included in the case studies on euthanasia. It seems to be a common agreement that the history of a doctor with 'a wonderful bedside manner' is so remote from any accounts of 'mercy killing' that it sounds almost like a blasphemy to hint that there is some connection. But it is precisely compassionate doctors whom we would imagine performing euthanasia, otherwise it would be indeed indistinguishable from a 'cold-blooded murder for selfish motives.'[217] The importance of the Shipman case is twofold. On the one hand it is in some respects strikingly similar to the histories of the other 'deadly' doctors, [218] which makes one wonder whether the situation would have been different had not his behaviour been so arrogant and stupid. On the other hand, since euthanasia is often associated with a merciful motive, the apparent absence of such in most of the doctor's cases creates the impression of their total unrelatedness to the phenomenon of 'mercy killing.' For the reader's consideration, here are some cases, which have the potential to be interpreted as active euthanasia.

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[213] Ibid.
[214] *EB*.
[215] Ibid.
[216] *EE*, 7.
[217] *EEPP*, 10.
[218] Expression used by Jim Paul, 'Euthanasia', *Nucleus*, October 1998, http://www.cmf.org.uk/pubs/nucleus/nucoct98/euth.html (26 July 2002).

Background

> Harold Fredrick Shipman was convicted at Preston Crown Court on 31 January 2000 of the murder of 15 of his patients while he was a General Practitioner at Market Street, Hyde, near Manchester and of one count of forging a will. He was sentenced to life imprisonment. Police have also investigated allegations that he may have murdered many more patients while he was a GP in Hyde and Todmorden.[219]

An official 2000-page report carried out by Dame Janet Smith and released on 19 July 2002 reveals another 200 victims and further 45 potential victims.[220]

Intention

Intention is crucial to distinguish euthanasia from a clinical mistake, incompetence or negligence. There is hardly any doubt that Dr Shipman fully intended the deaths of his patients, at least those of whose murder he was convicted. The evidence excludes the possibility that those deaths were a means of either covering sexual abuse or getting hands on the possessions of the victims.[221] So, why then is the majority still of the opinion that the actions of Dr Shipman have nothing to do with euthanasia? One reason is the general assumption that none of the deaths fits into the description of 'mercy killing'. True as it may be for the majority of Shipman's cases, it is nevertheless not the whole truth. There were, as we shall see, patients in the terminal stages of cancer who suffered immensely. Another reason is the lack of consent in most of his cases. For many people the word 'euthanasia' automatically associates with the adjective 'voluntary', which, as we already know, is not its only form. However, there are, as we shall also see, cases among Shipman's killings where the accompanying circumstances suggest that death might have been consented to or even requested.

Case 1

The youngest of Dr Shipman's victims was Peter Lewis, a 41-year old who had been his patient since 1982. Mr Lewis developed cancer of the stomach in 1984 and

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[219] 'Background to the Inquiry', http://www.the-shipman-inquiry.org.uk/backgroundinfo.asp (28 July 2002).

[220] 'Doctor's Catalogue of Death', *The Guardian*, 20 July 2002, 5.

[221] In the article 'Britain's worst killer. A Final Count: But Why Did It Happen?', *The Guardian*, 20 July 2002, page 23, it is acknowledged that 'there was "no suggestion of any form of sexual depravity"' and 'there was no evidence that he killed for monetary gain, except in the case of the last victim, whose will he altered'. And even in that last case 'his incompetent forgery delivered to the family solicitor made "detection inevitable", as though he needed to draw attention to himself'.

reached the terminal stage of it by Christmas that year. He was bed-bound and as the pain increased, the injections of morphine-based pain-killers were administered every two hours. Called in on 1 January 1985 by Mr Lewis' wife who noticed that her husband's breathing had become 'rattly' and his pain had worsened, Dr Shipman gave the patient an intravenous injection of an opiate, which was very likely to have been diamorphine. Mr Lewis died shortly afterwards.

Euthanasia or Palliative Care?

Dr Shipman, unlike Dr Bodkin Adams, 'was not in thrall to money'.[222] Neither was he using a poisonous substance, as Dr Nigel Cox did. Given the circumstances, whether what happened to Peter Lewis was euthanasia or proper palliative care depends entirely on the dose of diamorphine. The problem is that there seems to be no universally agreed measurement of a 'lethal dose', supposedly because of the nature of diamorphine and the variety of human condition. Dame Janet Smith, commenting on the case, asserts:

> Doctors in this position may face a difficult decision. They may realise that the dose they think will be necessary to relieve pain will also have the effect of shortening that patient's life. If the dose is given with the primary intention of relieving pain, the act is not only lawful, it is entirely proper. If, on the other hand, the doctor deliberately gives a dose which is larger than that necessary for the relief of pain, with the primary objective of bringing life to an end, that would be unlawful. [223]

Since in the case of Mr Lewis it is unknown[224] how much diamorphine Shipman gave, the only evidence of Shipman's intention 'is evidence of his words and actions that evening and the period of time which elapsed between the injection and the death'.[225] Although the timing appeared to be confused by the main witnesses, one thing Dr Shipman was heard to have said gives a helpful insight into what he might have thought. [226] Mr Lewis's wife recollects that in addressing the patient, he told him: 'Give

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[222] Michael Gove, 'The Motives of a Murder Addict', *The Times*, 20 July 2002, http://www.timesonline.co.uk/printFriendly/0,,1-2-360562,00.html (22 July 2002).

[223] The Shipman Inquiry - Case Decision, http://www.the-shipman-inquiry.org.uk/case_decision.asp?idx=c&id=DL&fn=23&from= (29 July 2002).

[224] However, there is a strong evidence that on a substantial number of other occasions, Shipman gave 30 mg instantly. Professor Henry McQuay (one of the medical experts in the inquiry) is reported to have said that it 'was a *potentially* lethal dose and that his professional colleagues would not let him go near them with a syringe loaded with more than 10 mg' [my emphasis].

[225] The Shipman Inquiry - Case Decision, http://www.the-shipman-inquiry.org.uk/case_decision.asp?idx=c&id=DL&fn=23&from= (29 July 2002).

[226] Having said that, I must admit that this case is probably one of the best to illustrate just how insufficient the evidence of words and actions can be in spotting the intention.

up, lad, we've all had enough. We can't take any more' or something with a similar meaning.[227] Dame Janet's conclusion is: 'I am quite sure that he had no moral or ethical scruples about hastening the death of a terminally ill patient. Indeed, I think it likely that he thought that when he did so he was doing the best thing for everyone concerned.[228]

In other words, the case of Peter Lewis has equal merits to be judged both as euthanasia and as palliative care. Assuming that the patient has never made any requests for it, it would have been an active involuntary euthanasia. But if Dr Shipman had spoken up and claimed that he was endeavouring to relieve the patient's suffering, there would have been no legal case whatsoever.

Case 2

Another cancer patient who is on the list of Shipman's unlawful killings was Mrs Rose Ann Adshead, who died on 18 September 1988 at the age of 80. She had been diagnosed with cancer of the rectum three months prior to her death. According to the inquiry report 'she had been in a great deal of pain and had said that it was becoming too much for her and that she wanted to die'.[229] She expressed this wish on the day of her death. Here is the sequence of events on that day as described in the inquiry report:

> Someone at the house telephoned the Donneybrook practice and asked that a doctor should visit. According to the duty doctor transfer diary, Shipman was the Donneybrook doctor on duty that day. Shipman arrived at the house at about midday ... Mrs Adshead was left alone with Shipman during the consultation. Shipman then came out of her bedroom and said that she was very unwell and that Mr Adshead 'would probably be calling him within an hour'. He then left ... Mrs Adshead appeared to be sleeping. From the time that Shipman visited, she did not open her eyes or say anything. About an hour after Shipman had left, Mr Adshead's uncle, Mr Bernard Tracey, said that Mrs Adshead had died. Shipman was called back to the house and confirmed that Mrs Adshead was dead.[230]

It is not known, since the consultation took place in private, what exactly Shipman did, but it has been assumed, given the agony Mrs Adshead was in, that he administered an injection of an opiate, most likely morphine or diamorphine. Although Dame Janet Smith thought it possible that Mrs Adshead's death 'was entirely natural',[231] she nevertheless suspected, given the time which passed between the injection and the

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[227] The Shipman Inquiry - Case Decision, The Day of the Death, http://www.the-shipman-inquiry.org.uk/case_decision.asp?idx=c&id=DL&fn=23&from= (29 July 2002).
[228] The Shipman Inquiry - Case Decision, The Day of the Death, http://www.the-shipman-inquiry.org.uk/case_decision.asp?idx=c&id=DL&fn=23&from= (29 July 2002).
[229] Ibid.
[230] Ibid.
[231] Ibid.

death, that 'the dose was not intended merely to relieve pain but was, instead, intended to end Mrs Adshead's life'.[232] If such was the case, euthanasia has clearly taken place. And remembering the wish Mrs Adshead expressed earlier that day, it may well have been what she wanted. This, in turn, makes it active voluntary euthanasia.

Post scriptum

The case of Dr Harold Shipman, as the above study shows, has a direct bearing on the problem of euthanasia. It reminds society just how slippery the slope is. In the treatment of terminally ill patients a lot, if not all, depends on the personality of the doctor. Were euthanasia legal in the UK, and were Dr Shipman's victims only terminally ill patients, the British 'Dr Death' would still be going round killing people. Even now, when euthanasia is not legalised, Shipman managed to carry on with his dreadful practice for more than twenty years with virtually no trouble whatsoever.

3. Miss B

In the previous cases I was looking at active euthanasia in the form of an injection of a substance which has no curative or analgesic properties and an overdose of a pain-killer lethal in itself. In my distinctions, however, I did not confine active euthanasia to these types. Withdrawal of medical devices with intention to cause death would also constitute an active form of euthanasia, since it would require precisely an action, not an omission. The following two cases qualify.

Before I go into details of this particular case, let me focus for a while on an interesting theoretical analysis of legal hypocrisy advanced by John Keown in *Euthanasia, Ethics and Public Policy*, as I consider it to be of great assistance in the analyses that follows.

There is an opinion that the Suicide Act 1961 created an inconsistency in the law by decriminalising suicide but leaving assistance in it a criminal offence. The misinterpretation of the Act consists in assuming that it established a 'right' to suicide. Keown argues to the contrary. He explains:

> Suicide, though no longer a criminal offence, remains 'unlawful'. It does not follow that, because conduct is not, or is no longer, a criminal offence, it is 'lawful', let alone that one has a 'right' to engage in that conduct...In short, the

[232] The Shipman Inquiry - Case Decision, Rose Ann Adshead, Conclusion, http://www.the-shipman-inquiry.org.uk/case_decision.asp?idx=c&id=DL&fn=23&from= (29 July 2002).

> Suicide Act created neither a right to commit suicide, nor a right to be assisted in suicide. On the contrary, it reaffirmed the unlawful nature of the act and underlined the prohibition on assisting or encouraging another to commit it. [233]

On the other hand, the law appears to have granted competent patients an absolute right to refuse any medical treatment, including life-support equipment.[234] Dame Elizabeth Butler-Sloss in *re MB* said that 'a mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death'.[235] The views of the BMA on the issue are similar:

> The law and codes of ethical practice emphasise that competent patients can refuse medical treatment, including life-prolonging procedures...Where adult patients refuse procedures that which are likely to benefit them, the BMA advises health professionals to provide information in a sensitive manner about the implications and explore with the patient whether relevant alternative options would be acceptable to the patient. Ultimately, however, the patient's view must be respected.[236]

Keown's concern is whether the law is consistent in prohibiting the doctors from assisting a patient's suicide by handing them, for example, a syringe filled with potassium chloride and at the same time allowing them to assist suicide by withdrawing or withholding life-saving treatments. He assumes the problem boils down to assessing the intention in withdrawing or withholding of medical life support. Keown's opinion is that the law as it stands is open to at least two kinds of interpretation.

> Indeed, it is arguable that, in order to avoid the injustice of doctors forcing treatment on patients who are wrongly suspected of refusing treatment with intent to kill themselves, the law could properly require doctors to respect all competent refusals of treatment, without in any way endorsing those which are suicidal. If, by contrast, the law were to require or even allow doctors *intentionally to assist* refusals of treatment which are clearly suicidal, then the law would indeed have fallen into serious inconsistency.[237]

If the doctor's intention in withdrawing life-saving equipment is the same as in injecting a syringe of potassium chloride, namely to cause death, there is no moral difference and both will be euthanasia. It has to be said, though, that unlike in the case of administration of pain-killers, where it is harder to establish death as being an inevitable consequence, in cases of withdrawing life-saving equipment death, except for some

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[233] *EEPP*, 65-66. Also footnote 20, 65.
[234] See the reference to one of the court cases in *EEPP*, 66, footnote 24.
[235] England and Wales High Court (Family Division) Decisions, *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), The Law on Mental Capacity, The Principle of Autonomy, 22 March 2002, http://www.bailii.org/ew/cases/EWHC/Fam/2002/429.html (24 July 2002).
[236] End of Life Decisions – Views of the BMA, Refusal of Treatment, http://www.bma.org.uk/ap.nsf/Content/End+of+life+decisions+-+June+2000#Refusal (27 July 2002).
[237] *EEPP*, 67.

kind of miraculous interference, is always inevitable. The question is whether by acknowledging an absolute right to refuse life-saving treatments for any reason the law has not already put doctors in a position of unavoidable assistance in suicidal refusals. If the law concentrates solely on establishing the competence of the patient and does not at all concern itself with the nature of intentions behind refusals how is it supposed to safeguard against intentional assistance in those that are clearly or supposedly suicidal?

The story

Miss B[238] was a single lady born in Jamaica who had been living in the UK since the age of 8. On 26 August 1999 Miss B suffered a haemorrhage of the spinal column in her neck. She was admitted to the hospital and diagnosed with a cavernoma, a condition caused by a malformation of blood vessels. During her stay in the hospital Miss B executed a Living Will, which stated that should the situation occur when she was unable to give instructions, she wanted the treatment to be withdrawn if she was suffering from a life-threatening condition, permanent mental impairment or permanent unconsciousness.[239] That time Miss B's condition gradually improved and she eventually returned to work. Thereafter she kept well apart from minor weakness in her left arm.

> The following happened more than a year later:
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> At the beginning of 2001, Ms B began to suffer from general weakening on the left side of her body, and experienced greater numbness in her legs. She felt unwell on the 12th February 2001, and was admitted to the Hospital in the early hours of the 13th February 2001. She had suffered an intramedullary cervical spine cavernoma, as a result of which she became tetraplegic, suffering complete paralysis from the neck down. On the 16th February 2001 she was transferred to the Intensive Care Unit (the ICU) of the Hospital. She began to experience respiratory problems, and was treated with a ventilator, upon which she has been entirely dependent ever since.[240]

Miss B told two consultants in the ICU that she had a Living Will and did not want to be ventilated. The answer was that the terms of her Will 'were not specific enough to authorise withdrawal of ventilation'.[241] This was obviously correct. Although Miss B's condition was indeed most grave, her illness was not progressive and thus could not be

[238] Her full name has never been disclosed to the media in the interests of confidentiality.
[239] England and Wales High Court (Family Division) Decisions, *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), Medical History, 22 March 2002, http://www.bailii.org/ew/cases/EWHC/Fam/2002/429.html (24 July 2002).
[240] Ibid.
[241] Ibid.

regarded as 'life-threatening' in the full sense. Neither was she in any way mentally impaired or unconscious. On the contrary, her brain was as vibrant as ever and her mental capacity was not in the slightest affected. On 23 March 2001 Miss B had neurological surgery at another hospital, which resulted in the ability to move her head and to speak. She also retained the ability to eat and drink.[242] After this and until 22 March 2002, the date of the hearing in the High Court, she was more or less persistent in her wish for the ventilator to be switched off. As the doctors in the ICU of the hospital where Miss B was did not agree to undertake such an action, and the situation of conflict increased with no prospective possibility of resolving it internally, Miss B went to court. The main issue for the judge, Dame Elizabeth Butler-Sloss, was to decide whether Miss B had 'the mental capacity to choose whether to accept or refuse medical treatment, in circumstances in which her refusal will, almost inevitably lead to her death'.[243] Emphasising that she was 'not asked directly to decide whether Ms B lives or dies but whether she, herself, is legally competent to make that decision',[244] Dame Elizabeth delivered a positive judgement.[245]

Intention

Following the adopted method in determining an act as euthanasia, I shall set out the evidence which in my view helps to assess the intention behind Miss B's wish for the ventilator to be switched off.

According to the competent medical opinion, shared by all the doctors who gave evidence in the court, 'if the ventilator were switched off the end would be in a few hours'. It was also indisputable that 'immediate withdrawal would cause her death'.[246] Therefore it is beyond any reasonable doubt that a doctor who turns the machine off will intend Miss B's death. Unlike injecting diamorphine, there is no place for the principle of 'double effect'. In this particular case the only consequence of switching the ventilator off is death and it is inevitable. It might be argued, of course, that the

[242] England and Wales High Court (Family Division) Decisions, *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), The Evidence of Ms B, http://www.bailii.org/ ew/cases/EWHC/Fam/2002/429.html (24 July 2002).
[243] England and Wales High Court (Family Division) Decisions, *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), The Issues, http://www.bailii.org/ ew/cases/EWHC/Fam/2002/429.html (24 July 2002).
[244] Ibid.
[245] Miss B was later transferred to another hospital, where the doctors were prepared to switch the ventilator off and have done so.
[246] England and Wales High Court (Family Division) Decisions, *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), The Medical Evidence, 22 March 2002, http://www.bailii.org/ew/cases/EWHC/Fam/2002/429.html (24 July 2002).

intention may be to relieve the suffering, but such a judgement would be as misplaced here as in the case of Dr Cox. First, it would be absurd to claim that the primary purpose is to alleviate suffering and distress and only secondary to stop Miss B's breath. Secondly, even if one accepts that the primary intention is either to relieve the suffering or to respect the patient's autonomy, the means of achieving it is death and hence the act is euthanasia.

Futile or burdensome treatment?

It can be argued that by switching the ventilator off Miss B avoided futile or burdensome treatment. I shall advance counter-arguments from both medical and spiritual points of view.

Medical considerations

Lord Goff, commenting on the implications of tube-feeding, remarked that this treatment is futile because 'the patient is unconscious and there is no prospect of any improvement in his condition'.[247] If these are the medical criteria of 'futility', than it surely does not apply to the situation of Miss B. She was fully conscious. And if the ventilator did not improve her condition as such, it was an important intermediate tool providing the opportunity for communication with others and thus offering a way to possible improvement. Paraphrasing Dr I, a consultant psychiatrist and a specialist in spinal injuries, removing the ventilator would bear in it a risk of removing potential benefits in the future.[248]

Miss B had a choice of possibilities:

- a rehabilitation programme;
- a place in a hospice;
- a weaning procedure.

According to Mr Alan Gardner, of the charity BackCare, for people like Miss B the following range of technical aids was available as part of rehabilitation:

- a tilted bed to help the patient sit upright;
- a spinal jacket to support her back;

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[247] Quoted by John Keown in *EEPP*, 218.

[248] England and Wales High Court (Family Division) Decisions, *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), The Medical Evidence, Dr I, 22 March 2002, http://www.bailii.org/ew/cases/EWHC/Fam/2002/429.html (24 July 2002).

- mechanical arms controlled by eye or mouth movements;
- keyboards activated in that way, allowing a patient to type.[249]

All of these would have enabled her to achieve a higher quality of life and to move back home from hospital. As Dr G put it, 'she would be able to go out into the community'.[250] Miss B rejected this offer on the grounds that it did not offer any possibility of recovery.[251] Admitting that the independence achieved through rehabilitation 'is an improvement', she nevertheless appeared to be convinced that it was insufficient for her:

> My view [about rehabilitation] is that it offers me no real opportunity to recover physically, that, in actual fact, it will be more teaching me to live with my disability and to make use of the technologies available and that sort of thing, working with carers. But, actually, I will not recover in any way. That is not acceptable to me.[252]

During one of the conversations with Dr Sensky Miss B acknowledged: 'I cannot accept myself as disabled and dependent – it's too big a leap to make. The totality of dependence is intolerable'.[253] However sympathetic and appreciative one may feel towards this position, the choice between cure or death is rather obvious. It is either physical recovery or non-existence. The middle way does not seem to be satisfactory.

As to the second opportunity, a place in a hospice, the court report states that Miss B 'refused the possibility of a bed in a hospice in December [2001] since the hospice would not accept her wish to have her ventilator withdrawn'.[254] This is the only reference to the opportunity of palliative care in this case. We do not know what it could have offered Miss B, but we do know that it was not given a chance.

The third possibility was a one-way weaning programme, 'agreed by the clinicians but with reluctance as an acceptable compromise'.[255] Weaning the patient off the ventilator presupposes gradually reducing the number of breaths supplied, so that the patient's body can get used to breathing on its own. Usually, if this does not happen, the number of breaths given would be restored to the previous quantity. A one-way weaning would mean reduction without going back on support. In this case 'sedation

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[249] BBC News/Health, 'Woman Pleads for Right to Die', http://news.bbc.co.uk/hi/english/health/newsid_1857000/1857754.stm (11 July 2002).
[250] England and Wales High Court (Family Division) Decisions, *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), The Medical Evidence, Dr G, 22 March 2002, http://www.bailii.org/ew/cases/EWHC/Fam/2002/429.html (24 July 2002).
[251] Ibid.
[252] England and Wales High Court (Family Division) Decisions, *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), Ms B's Wishes, 22 March 2002, http://www.bailii.org/ew/cases/EWHC/Fam/2002/429.html (24 July 2002).
[253] Ibid, The Medical Evidence, Dr. Sensky.
[254] Ibid, 8th August to the Hearing.
[255] Ibid.

would be given but not so as to cause respiratory depression unless clinically indicated'.[256] This possibility Miss B has also rejected, saying:

> I have refused the specialist clinic because weaning is essentially a long term treatment for patients who want to live without ventilation. This is not what I want, as it has no positive benefits for me given my level of disability ... I have refused this option because this would be a slow and painful death and my view of this is not disputed by the doctors ... My wish is to be sedated. I would expect it [turning the ventilator off as opposed to negative weaning] to be *a quick and painless death and less distressing for my loved ones.*[257]

The stress put by Miss B on the impossibility of improving the level of disability suggests that her decision to withdraw the ventilator was rather due to judging her own life as not worth living than to judging the treatments offered as futile or burdensome. It was the disability and dependence that were intolerable, not the treatment. The prospect of negative weaning, dreadful as it may be, was not the only one. Although the consensus was that 'without the help of artificial ventilation, according to the medical evidence, she would have a less than 1% chance of independent ventilation', this 0.9 %, or whatever it was, still existed. After all, who would have been in a position to guarantee that this tiny beam of hope would not have turned out to be a reality if a positive weaning was tried?

To close the discussion on medical concerns, it is helpful to remember two instances where the futility of treatment acquires certain plausibility. In the previous chapter I have referred to an example of particular medical conditions, where a patient needs to be on a ventilator at nights, but can breathe normally in the daytime. In this case keeping the ventilator on during the day can be properly considered to be futile, i.e. having no purpose. The other instance would occur when a person is in the process of dying, where the use of a ventilator is rather an additional and unnecessary burden than a benefit. Neither was the case with Miss B.

Spiritual concerns

Engelhardt in his guidance on spiritual concerns in decision-making at the end of life suggests that medical intervention should not be 'so encompassing or burdensome as to harm the spiritual life of the patient'.[258] Did the treatment that Miss B was

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[256] Ibid.

[257] England and Wales High Court (Family Division) Decisions, *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), One-Way Weaning Programme, Ms B's written statement, http://www.bailii.org/ew/cases/EWHC/Fam/2002/429.html (24 July 2002).

[258] *FCB*, 326.

receiving become so encompassing that it endangered her spiritual life? Her own account of her faith casts some light on this matter.

> In many ways the decision to have my treatment withdrawn has been a very difficult one for me as I have been a Christian and a regular church attendee all my life. The dominant view in the church is that I should wait for God to heal me. Withdrawing ventilation would be seen as throwing in the towel. I have questioned myself about this and it has challenged my integrity. It has been a very difficult process to rationalise what I am doing in the context of my faith but I feel there is no alternative, as I do not have any realistic hope of recovery. I have come to believe that people die and become disabled and God does not always intervene. It has also been difficult for me to contemplate leaving the people I love behind. There has been a lot of talking and crying as no one wants me to die but almost all of them empathise with me and my situation and sincerely wish to respect my wishes, which I have made clear to all.[259]

It is extremely sad to know that a person of strong will and apparently strong faith has ended up seeing recovery as the only way for God to intervene and chooses death. It is also a great pity that even such devoted Christians as Miss B find it no longer acceptable to be totally dependent on others. May be it is because these 'others', especially fellow Christians, find it no longer acceptable to give total care and often try to escape responsibility, often subconsciously, by believing that their real duty is to 'sincerely respect' someone's wish to choose death? I think the fact that Miss B 'did not have a supportive family'[260] significantly contributed to her willingness to cast out the suffering and not live it out. Also, having a strong character, she may have found it difficult to see her role as Christian to be anything less than an active minister. But even in her situation there still was a role. As another suffering lady once wrote in a letter to Stanley Hauerwas, 'when you can't preach, or teach, or confront, and you can only suffer, it is still possible to imitate Christ by bearing sufferings patiently'.[261] Taking all this into consideration I am inclined to think that the case of Miss B was not so much, if at all, about a spiritually harmful medical treatment, but about the failure 'to accept the cross of suffering and pain medicine cannot set aside by instead accepting a premature death'.[262]

> Summarising on this truly agonising case, I repeat after Keown:
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> If a patient says to a doctor: 'Doctor, I want to hasten my death. Please, help me', what is the moral difference between the doctor intentionally doing so by,

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[259] England and Wales High Court (Family Division) Decisions, *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), Ms B's wishes, 22 March 2002, http://www.bailii.org/ew/cases/EWHC/Fam/2002/429.html (24 July 2002).
[260] Ibid, The Medical Evidence, Mr G.
[261] Stanley Hauerwas, *Naming the Silences: God, Medicine, and the Problem of Suffering* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1990), 88.
[262] *FCB*, 326.

> on the one hand, giving the patient a lethal pill and, on the other, switching off the patient's life-support machine? ... if the doctor's intention is the same in both cases, where is the moral difference?[263]

There is none. To be sure there may be a technical difference that allows one to distinguish between euthanasia and physician-assisted suicide. The latter presupposes that the last act is carried out by the patient. This is not, as we know, what happened in the case of Miss B. To reinforce Keown's suggestion, I would say that there is no moral distinction between a doctor fulfilling his patient's request by deliberately injecting an ampoule of potassium chloride or a lethal dose of diamorphine and switching off the patient's life support. Both are actions and both intend death. It is indeed 'a distinction without a difference', because both cases are instances of active voluntary euthanasia.

4. Tony Bland

In *Euthanasia, Ethics and Public Policy* John Keown gives an in-depth analysis of the decision of the Law Lords to stop tube-feeding Tony Bland. As I largely agree with his argument and with the conclusions he reached, I do not see the need to repeat in my own words what has already been brilliantly expressed. What I do see, however, is the need, for the purpose of classification, to focus once again on the intention and whether the death in this case resulted from an act or omission.

The story

> Before his death on 3 March 1993, Tony Bland had lain in Airedale Hospital for over three years in a 'persistent vegetative state' (pvs), a state in which, it was believed, he could neither see, hear nor feel. The medical consensus was that he would never regain consciousness. Neither dead nor dying, his brain stem still functioned and he breathed and digested naturally. He was fed by nasogastric tube, his excretory functions regulated by catheter and enemas. Infections were treated by antibiotics. His doctor and parents wanted to stop the feeding and antibiotics and the Hospital Trust applied for a declaration that it would be lawful to do so...The declaration was granted by Sir Stephen Brown, whose decision was unanimously affirmed by the court of Appeal and the House of Lords.[264]

Unlike the patients in the previously looked at cases, Tony Bland was unconscious. Taking into consideration that his cerebral cortex was irreparably damaged, it is assumed that he was not experiencing either pain or suffering. The decision to discontinue the treatment therefore seems to have rested solely on the notion of the

[263] *EEPP*, 67.
[264] *EEPP*, 217.

patient's best interests and since he could not express his own views, relied totally on the 'substituted judgement' delivered by his medical team and his parents. Whether these are valid legally is not for me to speculate on, neither is it my concern in this case. What I shall try to establish is whether the nature of intention in stopping Tony's tube-feeding would be compatible with euthanasia and if so, whether it was an active or a passive form of it. If it was euthanasia, due to the patient's inability to participate in the decision, it would have been a non-voluntary one.

Intention

It merits reminding ourselves, as this simple fact tends to be easily overlooked in the thicket of arguments that it was in Tony's 'best interests', that the inevitable result of withdrawing the tube-feeding would be Tony's death of 'starvation and dehydration'.[265] Since we assume that he was not suffering, one cannot claim the primary intention to relieve it. It is not in any dispute that the doctor's withdrawal of the nasogastric tube 'was causative of the patient's death'.[266] It was also maintained that such a course would be lawful, 'even (according to a majority) with intent to kill'.[267] Given this, it is beyond any reasonable doubt that euthanasia has taken place.

Active or passive?

Interestingly, a disagreement seems to exist as to the active or passive nature of stopping the tube-feeding. Keown for the purposes of distinguishing between medical treatment and basic care separates the presence of the tube and '*the pouring of food and water down the tube*'.[268] If one starts from this premise, the doctor who intentionally stops the flow of food and drink down the tube is performing euthanasia by omission. The doctor who withdraws the tube in order to remove the means for pouring food and water or who switches off the mechanism (if there is such) which automatically pours food and liquid at pre-set times, is performing euthanasia by action. In the case of Tony Bland the action has taken place. The commentary on the judgement states:

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[265] *EEPP*, 235.
[266] Airedale NHS Trust v. Bland, *MLR*, 1, Autumn 1993, 366.
[267] *EE*, 2.
[268] *EEPP*, 219.

> On the facts, the judges categorised the withdrawal of hydration and nutrition as an omission (i.e. to provide care) rather than an act even though the result could only be achieved through positive conduct by pulling out the tubes.[269]

It is somewhat mysterious how the judges managed to describe as an omission, i.e. failing to act, the type of undertaking so evidently active as 'pulling out the tubes'. I am not at all persuaded to follow this kind of twisted reasoning and therefore consider Tony Bland's death to be active non-voluntary euthanasia.

III. Passive Euthanasia: Dr Leonard Arthur

An example of passive euthanasia is presented in the case of Dr Leonard Arthur, which is summarized below:

> ... baby John Pearson was born on Saturday morning 28 June, 1980 at Derby City Hospital. It was a normal birth, but the midwife immediately recognised Down's syndrome. Otherwise the baby was apparently healthy. The mother was distraught on hearing of the child's mongolism, and became more definite than most in saying that she did not want the child. Dr Arthur, the consultant pediatrician, saw the baby at noon, and after discussion with the mother, noted 'Parents do not want the child to survive. Nursing care only.' He then prescribed regular doses of the drug dihydrocodeine, which in his later statement to the police he indicated was used by him as a sedative 'which stops the child seeking sustenance'.
>
> There was some dispute in court, and later in the press, about the meaning of 'nursing care only'; in John Pearson's case it was interpreted to mean that he should be kept 'comfortable, warm and cherished' and fed with water but given no milk. The baby developed bronchopneumonia, and became critically ill by the Sunday evening. He died at 5 a.m. the following Tuesday morning, 69 hours old.
>
> The organisation LIFE gave some evidence to the police, and on 5 February, 1981 Dr Arthur was charged with murder. In the course of the trial (which began on 13 October, 1981), evidence came to light which indicated that death could have been caused by a congenital heart condition from which the child may have been suffering from birth, and/or bronchopneumonia. The charge of murder was dropped in favour of the charge of attempted murder.
>
> The jury decided that the prosecution had not convinced them that Dr Arthur had attempted to murder John Pearson, and he was acquitted on 5 November, 1981.[270]

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[269] Airedale NHS Trust v. Bland, *MLR*, 365.

[270] *TB*, 202-3, also footnotes 3-7 on these pages.

Intention

It is clear that the doctor's intention in this case was to bring about the child's death. Baby John was deliberately deprived of milk, which is normal 'food' for the newborns. This would have resulted in the only and inevitable consequence of starvation to death. The fact that according to the adopted interpretation of 'nursing care only' the child was 'fed with water', is totally incomprehensible. I cannot quite grasp how anyone, including a baby, can survive on water only. One may call it hydration, for sure, but not nutrition. The other crucial factor is that John Pearson was not dying. Sometimes in the last stages of cancer the patients would be given only water, but no food, but that is a different situation altogether. It will in most cases be the patient's wish not to eat anything, not because the intention is to starve to death, but simply because the patient's death is near due to the progress of the illness, which medicine is powerless to stop. The baby did seek to be fed, but was not only denied that, but deliberately rendered 'mute' by sedation.

The discovery at trial of 'a congenital heart condition from which the child *may* have been suffering from birth'[271] does not change the doctor's intention one whit. He did not make any reference to any kind of serious health problem at the time he prescribed 'nursing care only.' The only thing he mentioned in his initial note was the fact that parents did not want the baby to survive. In other words, they wanted the baby to die. The argument that the doctor's intention was therefore simply to respect the mother's choice does not hold water. It may well have been a motive, whether a good or a bad one, but not the intention.

Active or passive?

Dr Arthur failed to act, with intention to cause death twice. First, when he did not provide nutrition for the baby. He decided precisely not to take an action in this respect. The second time he neither took any steps to treat a supposed heart condition (there is no evidence to indicate that it was medically untreatable), nor gave any medication to treat bronchopneumonia. There is strong evidence that he chose to be totally passive not because the treatment would have been futile in terms of a 'medical indications policy' approach, as, for example, Dr Zachary would have done, but precisely because he agreed on the futility of the baby's life.

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[271] *TB*, 203 [my emphasis], also footnote 7 on this page.

To summarise, what Dr Arthur has done (or rather has not done) can be regarded as passive non-voluntary euthanasia.

IV. Assisted Suicide: Diane Pretty

In 2001 every British citizen came to know of Diane Pretty due to the immense publicity that accompanied her legal case. The story was unprecedented in its scale and had a significant impact on public opinion. Legally Mrs Pretty's plea went from the Divisional Court all the way to the European Court of Human Rights and although the decision sought was not granted, it stirred up the English judicial system quite significantly. In terms of public ethics the media coverage created a situation where virtually everyone had been participating in the decision about Diane's life and death.

The legal implications of the case are thoroughly discussed by John Keown in the *Afterword* to *Euthanasia, Ethics and Public Policy* to which I take the liberty simply to refer the reader and allow myself to concentrate in more detail on the intention which has been the focus of the legal battle and on the medical side of the case, which has received much less scrutiny than the legal one. For a proper perspective in understanding the issues at stake it is crucial that the balance should be restored.

Background

Mrs Diane Pretty of Luton, Bedfordshire, was diagnosed with Motor Neurone Disease (MND) in November 1999 at the age of 40. She was living together with her husband, their daughter and granddaughter. The disease had reached an advanced stage in July 2001, when the first steps in what was to become a legal fight were taken. By that time Diane has become paralysed from the neck down, has almost lost the capacity to speak and had to be tube-fed. However, her mind remained intact.

On 27 July 2001 in a letter written on her behalf Mrs Pretty asked the Director of Public Prosecutions (DPP), David Calvert-Smith, 'to give an undertaking not to prosecute the applicant's husband should he assist her to commit suicide in accordance with her wishes.'[272] On 8 August 2001 Mrs Pretty's solicitor received a negative answer to this request. On 20 August an application was made to the Divisional Court for the judicial review of the DPP's decision, which was refused on 17 October 2001. With the

[272] *Pretty v. the United Kingdom*, European Court of Human Rights, Fourth Section, Application no.2346/02, Judgement, 29 April 2002, The Facts, The Circumstances of the Case, http://hudoc.echr.coe.int/hudoc/ViewHtm...0&Noticemode=&RelatedMode=1&X=72620160(26 July 2002).

help of her legal team Diane Pretty appealed to the House of Lords, which on 29 November 2001 unanimously upheld the judgement of the Divisional Court. The last legal resort for the Prettys was the European Court of Human Rights in Strasbourg. The application was lodged with the Court on 21 December 2001, a public hearing took place on 19 March 2002 and the judgement was delivered on 29 April 2002. It was not in favour of the applicant. Diane Pretty died on 11 May 2002.

Intention

There is no ambiguity about what Diane Pretty was trying to achieve. According to her barrister, Philip Havers QC, who spoke before the Divisional Court judges,

> She requires and wishes the active assistance of a third party in carrying out some of the steps leading to her death although the last acts that lead directly to her death will be carried out by herself. In essence Mrs Pretty's wishes are that someone else, namely her husband Brian, assist her in committing suicide.[273]

Diane's intention, although not the circumstances of the situation, seems to be quite similar to that of Miss B in that she wanted death as opposed to protracted suffering. Before the ruling of the Law Lords Mrs Pretty said: 'I have tried every type of medical treatment and fought this disease every step of the way. If I am allowed to decide when and how I die, I will feel that I have wrested some autonomy back and kept hold of my dignity.'[274] As with Miss B, the emphasis is on the lack of autonomy and the absence of dignity in suffering as seen by the patient herself. But it has to be noticed that increasing dependence does not have to diminish one's dignity. Also, one can exercise control in how one dies without recourse to suicide.[275] To equate lack of autonomy with lack of dignity is to adhere to a misguided and morally dangerous judgement. Diane Pretty, like Miss B, was totally dependent on others and they both seem to have found this undignified. The terrible irony in both cases was that the choice which was supposed to end the indignity of dependence could not have been exercised outside this very dependence. Both women seem to have thought that the victory of dignity is either cure of the disease or termination of life. Since cure was not possible to achieve, death emerged as the only option in the most extreme circumstances. However, on closer

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[273]Case No: CO/3321/2001 IN THE SUPREME COURT OF JUDICATURE QUEENS BENCH DIVISION (DIVISIONAL COURT), 17 October 2001, http:// www.courtservice.gov.uk/judgmentsfiles/j389 /Pretty_v_DPP_SSHD.htm (4 June 2002).

[274] John Chapman, 'How Dare the Judges Condemn Me to Live', *Daily Express*, 30 November 2001, 1, 6, column 5.

[275] The possibility of this control is one of the purposes of palliative and hospice care.

examination of the facts it appears that other options were there for Mrs Pretty as they were for Miss B. I shall discuss them further on.

The framework developed by Keown shows the importance of distinguishing intending death from foreseeing it. As it was put in the Divisional Court's judgement, in the case of Diane Pretty the judges were 'being asked to allow a family member to help a loved one die, in circumstances of which we know nothing, in a way of which we know nothing'.[276] In other words, the only thing that seemed to have been clearly established is that it was a request to terminate one's life. Death was presented as a desired end and therefore explanation of the means of bringing it about has taken the back stage. Mrs Pretty's case was not, using Ramsey's description, about comparing '... a certain state or condition of dying with another, one treatment with another, or treatment with no treatment',[277] it was precisely about comparing a certain state or condition of living with non-existence and choosing the latter. Therefore death could not have been simply a matter of foresight. It was intended.

The argument could have taken quite a different stance were there a question of potentially 'futile or too burdensome treatment'. Were Diane Pretty dependent on an artificial device like Miss B the issue at stake would have been to decide whether it was indeed futile or too burdensome or both. If, for the sake of the argument one would imagine Diane swapping places with Miss B, the intention behind withdrawal of ventilator could well have been to avoid futile, i.e. medically useless treatment. Mrs Pretty was in the process of dying, her disease constantly progressed and in this case the use of a ventilator would have had no real or potential benefits and thus would appear truly burdensome. And if she had in this hypothetical situation chosen to seek a court decision to remove the ventilator, her intention would clearly be justified legally, as well as morally. It would have been neither euthanasia nor assisted suicide.

Likewise, it is interesting to see how the case of Miss B could have been interpreted had she not been in the hospital, but at home with a family, just like Diane Pretty. It seems that, given the grounds for her decision remained as they were, had she asked for her husband's help in bringing death about she would most likely not have been granted her wish. In terms of physical ability both Miss B and Mrs Pretty were in the same position at the time of the legal procedures. And if by 'the last acts that lead directly to her death' Diane's lawyer meant that she would, for example, swallow the lethal medication provided by her husband, surely Miss B was capable of doing the

[276]Case No: CO/3321/2001, The Human Rights Arguments, Articles 8 and 9.
[277] *EEL*, 148.

same. In the interview with Dame Elizabeth Butler-Sloss, Miss B discussed among other subjects the possibility of assisted suicide. Having been asked whether she would turn the ventilator off herself were the appropriate mechanism provided, she replied: 'If I was desperate before and there were no other way, of course, as a last resort, I would do it.'[278] She added though, that she herself would not see it as suicide. Sadly, Mrs. Pretty must have found herself much closer to this last resort than Miss B, the last resort to exercise the choice of death.

Both cases were widely presented as legal fights for the 'right to die',[279] unsuccessful for Diane Pretty and successful for Miss B. If the latter was finally able to enjoy this right, why was it denied to the former? In this respect, the law appears to have been inconsistent, at least from a moral point of view. Indeed, if Miss B's intention was the same as that of Mrs Pretty, has the law not thereby allowed her to commit suicide?[280] One has to distinguish between the 'right to die with dignity' and the 'right to choose death'. These rights are not and should not be interchangeable. If Mrs Pretty was fighting to have a ventilator switched off, she would have indeed fought for her right to die with dignity. However, what she has fought for was the right to choose death by committing assisted suicide. If Miss B's request to switch off the ventilator was made with a suicidal intention and as we have seen there is some evidence to that effect, then her fight was indeed the same as that of Diane Pretty: not for the right to die, but for the right to choose death. It is important both ethically and legally, to tell the difference.

Medical side

Throughout the duration of Diane Pretty's case the media coverage pressed hard the fact that in preventing assisted suicide, the legal system and, one step removed, society on the whole, was condemning the woman to a terrible death by 'progressive suffocation'.[281] One of the news articles commissioned already after Diane's death

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[278] BBC News, Health, 'Right-to-die woman gives evidence', http://news.bbc.co.uk/hi/english/health/newsid_1861000/1861002.stm (11 July 2002).

[279] See, for example: Clare Dyer, 'Paralysed Woman Wins Right to Die', *The Guardian*, 23 March 2002, http://www.guardian.co.uk/uk_news/story/0,3604,672723,00.html (24 July 2002) on the case of Miss B; Clare Dyer, 'Final Right to Die Plea Rejected by Court', *The Guardian*, 30 April 2002, http://society.guardian.co.uk/health/story/0,7890,707596,00.html (24 July 2002) on the case of Diane Pretty.

[280] See Keown's argument regarding the alleged right to commit suicide by refusing treatment in *EEPP*, 66-68.

[281] AC Grayling, 'A Good Death'. *The Guardian,* Saturday Review, 27 October 2001, 1-2. This theme is carried on in many more publications. See, for example: Polly Toynbee, 'For Those Who Wish to Die the Law is a Cruel Torment', *The Guardian*, 22 August 2001, 5.

informed the reader that 'she feared the choking and asphyxia *often caused* by her disease'.[282] Nobody would deny the fact that MND is one of the most distressing and terrible illnesses, but one has at least to get the medical facts right, if one wants to use them in the argument. It is quite disturbing to find that the medical side of the story has been constantly misrepresented, thus creating a totally wrong bias in the public opinion. The simple fact is that there is no medical evidence as to choking or suffocation being the causes of death from MND. Indeed, there is strong evidence that they are not. The MND Association lists death by choking or suffocation as myths:

> The most common cause of death in people with MND is respiratory failure due to weakness in the muscles and death is very peaceful. It is very rare for someone to die from choking to death. People will never suffocate as a result of MND.[283]

This statement of the MND Association is backed up by the vast data of clinical research collected by hospices.[284] In the study conducted at St Christopher's hospice only one in 100 deaths has been attributed to choking. Moreover, post-mortem showed that even in this single case the airways of the person were clear.[285] Among other myths quoted by the Association are the ideas about MND being untreatable and that people affected lose all ability to communicate. It is true that this disease is at present incurable, but it is false to think that there is no treatment for it. As the MND Association explains, 'the drug riluzole (brand name Rilutek) is known to slow down the progression of MND by between three and six months. Treatments are also readily available for the individual symptoms of the condition.'[286] Communication is not completely cut off. There is a variety of means available including 'Lightwriters, computers and even blinking.'[287]

This evidence casts serious doubts on the contention that to refuse assisted suicide would be tantamount to inflicting 'inhuman or degrading treatment' on Mrs Pretty. Was Diane aware of the possibilities offered by palliative care services? At the hearing in the Divisional Court her barrister, Mr Havers 'said simply that Mrs Pretty *has*

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[282] BBC/HEALTH, 'Diane Pretty Dies', http://news.bbc.co.uk/1/hi/health/1983457.stm (12 August 2002) [my emphasis].
[283] Motor Neurone Disease Association website, Press Office, MOTOR NEURONE DISEASE - MYTH OR REALITY? http://www.mndassociation.org.uk/full-site/press/office.htm#myth (9 August 2002).
[284] See: D.J. Oliver and C. Saunders, 'Motor Neurone Disease' in Patricia A. Downie (ed.), *Cash's Textbook of Neurology for Physiotherapists* (London: Faber & Faber, 4th ed., 1986), 459-68; Tony O'Brien, Moira Kelly, C. Saunders, 'Motor Neurone Disease: A Hospice Perspective', *BMJ*, Vol. 304, 22 February 1992, 471-3.
[285] Cicely Saunders, Thomas D. Walsh and Mary Smith, 'A Review of 100 Cases of Motor Neurone Disease in a Hospice' in Cicely Saunders, Dorothy H. Summers and Neville Teller (eds.), *Hospice: The Living Idea* (London: Edward Arnold Ltd., 1981), 126-47.
[286] MOTOR NEURONE DISEASE - MYTH OR REALITY?
[287] Ibid.

not been offered any such care.'[288] However, it is well known that Diane spent her last days at the Pasque Hospice in Luton, near the place where she lived, where she was given care of outstanding quality. As her husband said afterwards: 'The staff were wonderful at their job and there was always someone there with her.'[289] Dr Ryszard Bietzk, medical director of the Pasque Hospice has commented on Diane's death saying that it was 'perfectly normal, natural and peaceful.'[290]

In one of the TV programmes after Diane's death, Brian Pretty reaffirmed that the care provided by the hospice was excellent, but said it was not what Mrs Pretty had wanted. This simple statement puts the whole case in the right perspective. It was indeed a question of choosing between 'dignified' and 'undignified' death. Only the public seemed to have been confused as to which is which. The story of Diane Pretty should be alarming for society not because she has not been allowed to commit suicide, but because surrounded by a loving family she had come to want it, in spite of medical technology and palliative care being 'advanced to a level where most people in the developed world, including those with motor neurone disease, are able to die comfortably.'[291] Watching the programme I couldn't help having an uneasy feeling that the whole campaign was conveniently utilised by the VES, which, while being concerned about Mrs Pretty, has nevertheless tried to pave the way to its goal through the legal system at her expense.

V. Conclusion

Pitifully, the way in which the widely publicized euthanasia related cases have been presented has not so much informed the debate as further confused it. To claim that cases such as that of Dr Shipman and Miss B have no direct bearing on the problem of euthanasia or assisted suicide is shortsighted. To equate good medical practice or palliative care with euthanasia, lack of autonomy with lack of dignity and choosing death with a right to die with dignity is to miss crucial distinctions. It would be a bad resolution of the modern ethical tensions to choose between medical technology overtaking our lives and exercise of self-termination. Although this can be seen as the only choice, thankfully it is not and as Christians we hope it will never be. Therefore,

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[288] Case No: CO/3321/2001, Judgement, The Facts [my emphasis].
[289] BBC/HEALTH, 'Diane Pretty Dies'.
[290] Ibid.
[291] The Christian Medical Fellowship, 'Diane Pretty – Statement on House of Lords Decision', 29 November 2001 http://www.cmf.org.uk/press/291101.html (27 July 2002).

careful evaluation of the inner rationale of end-of-life decisions is called for nowadays more than ever in the past. Not only is it of significance in balancing bioethical theory and practice. If not pursued with due determination, it is likely to leave modern society without any recognized public morals.

In most of the cases where people turn to euthanasia or assisted suicide these are believed to be the only option or the last resort. The above stories show they do not need to be. Palliative and hospice care have either not been considered or have been rejected. It largely happens due to a lack of knowledge as well as a lack of understanding of the meaning of these concepts. Therefore it is vital to fill the gap.

CHAPTER V

HOSPICE V EUTHANASIA

I. Introduction

The aim of this chapter is threefold. First, it is to give a general idea of what the hospice movement and palliative care is about, secondly, to explain how it can be distinguished from the practice of euthanasia, and finally, to show that the hospice can be a particular type of Christian community serving the needs of the vast majority, if not everyone, in a world 'marked by a plurality of moral visions.'[292]

In the country where modern hospices originated and the standards of terminal care have become exemplary, it is inexcusable that somebody like Diane Pretty 'has not been offered any such care.'[293] Paradoxically, after more than thirty years since the modern hospice movement started, the knowledge about it in the UK itself is far too superficial and sometimes even non-existent. By contrast, the flow of information about euthanasia and assisted suicide is overtaking it in quantity, if not in quality. In the cases discussed in the previous chapter the information regarding the possibilities of palliative and hospice care is scant and very much matter of fact. The fact that euthanasia and assisted suicide have acquired such an appealing stance is not least due to them being presented as the only dignified and merciful way out in certain circumstances, the number of which is continuously expanded. However, instead of trying to stretch exceptions to change the rule it would be wise to find opportunities for the rule to lessen the number of exceptions. These opportunities are already embodied in the hospice philosophy and constantly develop. One cannot possibly put them aside.

It is not only ignorance in terminal care matters that prevents people from giving a fair hearing to the alternatives to euthanasia and assisted suicide. Even when people know about hospices and palliative care, there is among many a grievous misconception that these are but part of the practice of euthanasia. In the sense that hospice philosophy promotes a chance for a good death for every person, it is certainly true. In the sense that it represents yet another way of killing patients, it is certainly not. The trouble is,

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[292] *FCB*, 42.

[293] **R (on the application of Pretty) v Director of Public Prosecutions and another*, Judgement, The Facts, cited above (see footnote 284).

again, the lack of clarity in definitions. I shall endeavour to examine what good terminal care involves and how to distinguish it from euthanasia. Failure to draw the line between the two has already led, as Keown shows, both to ethical and legal hypocrisy.

The Christian roots of the modern hospice movement are an advantage and a disadvantage at the same time. The advantage that Christianity gives the movement is the spirit which holds it together and places it in the context of the transcendent. The disadvantage is that it can be seen as too narrow and too demanding. In the century when disbelief on the one hand and a broad concept of spirituality on the other have often replaced institutional religion, some people are reluctant to embrace the hospice philosophy for fear of being forced at the end of their lives into a totally alien setting. Years of experience have demonstrated that this need not happen. Indeed, hospices reaffirm that unity in diversity which Engelhardt attributes to a libertarian type of society. Somehow the idea on which a modern hospice is based affords a combination of universality and particularity without abusing either. This is a phenomenon that merits not mere recognition but earnest attention and vigorous support. The story of St. Christopher's Hospice started the history which brought Christianity of the first millennium into the reality of the twenty first century. It has fulfilled the expectations both Ramsey and Engelhardt have expressed. On a personal level the hospice way of death[294] offers an opportunity to turn from oneself to God, to reach out for holiness whilst at the same time incarnating on the public scale that vision of secular morality 'extended from the church of Jesus Christ.'[295]

I shall start with an overview of the development of hospices from the first institutional provision for the dying established in 1879 to the foundation of St. Christopher's Hospice in 1967, which has come to be a symbol of the modern hospice movement. Having started in the British Isles as a revolution in terminal care it has now spread all over the world and has changed the face of healthcare on the global scale. Remarkably, this was done almost single-handedly by a determined Christian woman. In Russia a man has followed her example, for fifteen years fighting the great silence of the Soviet era on his own. Although with a different personal and cultural background they share the same idea and show the same power of commitment. The differences and similarities in hospice work in Britain and in Russia will be the background against which I shall explore the distinction between palliative care and euthanasia and the role of hospices as Christian communities.

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[294] This phrase stands as the name of a book: Paul M. Du Bois, *The Hospice Way of Death* (New York/London: Human Sciences Press, 1980).
[295] Hauerwas quotes Ramsey in *WW*, 129-30.

II. The History of the Hospice Movement

The word 'hospice' derives from the Latin *hospitium*, from *hospes* – a stranger, guest.[296] It was first coined in Rome in the late fourth century AD.[297] During the early Christian era it was used to describe 'a place where hospitality was offered to pilgrims and other travellers as well as the sick and destitute.'[298] Initially these early establishments were neither particularly concerned nor specifically devised for the care of the dying, although many of the 'strangers' and 'guests' must have ended their lives in the early hospices. The first institution to use the word 'hospice' strictly in relation to the dying was a home founded by Mme Jeanne Garnier in France in 1842.[299]

1. The Rise of Homes for the Dying in Britain

Independently from Mme Garnier's initiative, in 1879 the Irish Sisters of Charity, a Catholic monastic order, opened Our Lady's Hospice for the Dying in Dublin. This venture pioneered the linking of hospices with specialized care for the dying in Britain and became a prototype of the broader concept of the 'hospice movement' which was to evolve in the 1950s in this country. It marked a period of revival following the decline that hospices experienced between the Middle Ages, where they 'played an important role in the development of the first hospitals',[300] and the late Victorian era with its concern for provision of an adequate care for the dying 'respectable or deserving poor.'[301] The network of the voluntary run hospitals which used to provide for the medical needs of this particular type of lower class members tended 'to give priority to patients who were considered useful for the research and education of medical practitioners.'[302] Incurable cases were seen as not fitting these purposes and apart from being a burden on the hospital's budget, the dying patients did not contribute positively to its overall image as an institution of health. After discharge

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[296] *The Chambers Dictionary* (Edinburgh: Chambers Harrap Publishers Ltd, 2nd ed., 2001), 775.
[297] Robert Kastenbaum, 'The Moment of Death: Is Hospice Making a Difference' in Inge B. Corless and Zelda Foster (eds.), *The Hospice Heritage: Celebrating Our Future* (New York: The Haworth Press Inc., 1999), 256.
[298] Cicely Saunders, 'A Hospice Perspective' in K. Foley and H. Hendin (eds.), *The Case Against Assisted Suicide: For the Right to End-of-Life Care* (Baltimore: John Hopkins University Press, 2002), 283 [hereafter abbreviated *CAAS*].
[299] *CAAS*, 283.
[300] Clare Humphreys, '"Waiting For the Last Summons": The Establishment of the First Hospices in England 1878-1914', *Mortality* 6/2 (2001), 147 [hereafter abbreviated WLS].
[301] Ibid, 151.
[302] Ibid.

from the hospital, the dying poor, unlike the members of the middle and upper classes of Victorian society, were, by and large, unable to receive proper medical, nursing and spiritual care at home. This gap within medical practice of that time needed to be filled in. Here was the breath of a new life for the somewhat forgotten hospices:

> The idea was to admit patients who had been discharged from the hospitals as incurable, and who were suffering from diseases which, in the natural course of events, would likely prove fatal within a period of a few months.[303]

However, the nuns of the Irish Sisters of Charity were unable to put this idea into practice due to the lack of space in any of the Dublin convents to accommodate such an undertaking. The opportunity began to materialise when the Motherhouse and Noviciate were removed from Harold's Cross to a new location. The old building was then converted into a home suitable for the dying patients with a capacity of twenty-seven beds. In 1886 a larger building was commenced with an intake of 110 patients. For the first several decades of its existence it provided end-of-life care mostly for those suffering from tuberculosis, but with the elimination of this disease by the 1940s it gradually reoriented itself to palliative services for cancer and other acute terminal illnesses and general nursing care of the chronically ill and elderly. More than a century later Our Lady's Hospice is still successfully functioning. A brand new palliative care complex with 36 in-patient beds and a day centre was officially opened in 1993.[304]

Apart from making up for the shortcomings and deficiencies of the healthcare system, hospices were to cater for the spiritual needs of the dying. In a certain way they became an important antithesis to the increasing secularisation of death.

> A longer life expectancy, improved medical treatment and a declining mortality rate reduced the immediacy of death; naturalistic explanations for disease, a declining belief in the doctrine of hell and the relevancy of salvation undermined the need to minister to the soul...The creation of institutions committed to helping patients undergo spiritual preparation for death...ran counter to these developments.[305]

Continuing the long-standing Christian tradition of the ministry to the sick and dying four out of five hospices established in London at the turn of the nineteenth century were affiliated to a religious sisterhood. The Hostel of God founded in 1891 in Clapham was run successively by the Sisters of St James' Servants of the Poor and the Sisters of St Margaret's of East Grinstead. Two years later in 1893 St Luke's House was opened

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[303] WLS,147.
[304] The Hospice History Project, Timeline of Hospice Development in the United Kingdom and Ireland, 1870-2000, A Listing of Hospices by Founding Year, 1870-1900, Our Lady's Hospice for the Dying, http://www.hospice-history.org.uk/period1.htm (17 August 2002).
[305] WLS, 154.

by Dr Howard Barrett, the Medical Superintendent of the Methodist organisation the West London Mission. The Home of the Compassion of Jesus opened in 1903 belonged to the Anglican Community of the Compassion of Jesus. In 1905 Fr Peter Gallwey, a Jesuit priest, established St Joseph's Hospice for the Dying in the East End of London in Hackney. As Our Lady's Hospice, it was run by the Irish Sisters of Charity.[306]

The fifth home for the dying was set up by Miss Frances Davidson in Mildmay Park in 1885. It was called Friedenheim and seems to have been meant as part of the network of non-religious hospices planned by the cancer hospitals at the end of the nineteenth century, which nevertheless never fully flourished. The reason for the failure of this secular type of hospice is worth noting, as it proved to have influenced the mindset of the medical profession far beyond expectations:

> The competing demands for the support of clinical laboratory research into cancer were given priority, in the hope that discovery of a cure would remove the need for such 'Friedenheims'; this shift in emphasis has had lasting influence on provision for cancer and cancer patients.[307]

First hospices for the dying were also a new trend in philanthropic developments. They gave a splendid opportunity for a visible result of charitable activities. And the importance of charitable deeds was backed up and encouraged by all Christian denominations, particularly by the then enormously influential evangelical church.

> To summarise, the shared basis of the first hospices was
>
> the provision of bodily and spiritual care within a home-like atmosphere for the respectable poor who were medically certified as 'dying' and whose domestic and family circumstances meant that they could not be nursed at home.[308]

This overall basis remained almost intact up to the second half of the twentieth century when it was given a new form.

2. From St Luke's and St Joseph's to St Christopher's

Two of the early hospices, St Luke's and St Joseph's played a major role in developing the philosophy of terminal care which was later to shape the modern hospice movement.

In 1948 Cicely Saunders, a 30-year-old medical social worker telephoned St Luke's House and soon was helping there as a volunteer sister in her spare time. Her

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[306] WLS, 149.
[307] Caroline C. S. Murphy, 'From Friedenheim to Hospice: A Century of Cancer Hospitals' in Lindsay Granshaw and Roy Porter (eds.), *The Hospital in History* (London/New York: Routledge, 1989), 221.
[308] WLS, 161.

motivation for coming to St Luke's was both professional and deeply personal. From her work as a nurse she knew she had that rare gift of relieving people's suffering and it strengthened her wish to be with the dying. Talks with David Tasma, the man whom Cicely loved and who was one of her patients while she was an almoner, helped to shape her ideas. David was dying from cancer at Archway Hospital and Cicely was his only visitor. They discussed what could be done for many others like him, who were ending their lives desperately alone and in great pain. When David died, he left Cicely five hundred pounds towards the future project of a home for the dying of a new type. That was a 'window',[309] round which to build the house that Cicely longed for but did not yet visualise.

A qualified nurse, Cicely often witnessed the officious striving to cure the incurable and the abandonment of the dying patients who no longer responded to the aggressive treatment offered by contemporary medicine. Often seen as disturbing cases illustrating the limits of medical power, these patients were left to die comatose from drugs or in a state of an ongoing unrelieved pain. As in the late nineteenth century, in the 1940s those who suffered from terminal illnesses found themselves outside the healthcare system from the moment when all curative efforts were exhausted to the time of death. The hospices that already existed by that time were the only places where the complex needs of the dying were understood and an attempt made to meet them. Dr Howard Barrett, the founder of St Luke's House, thus described the hospice philosophy:

> We do not think or speak of our inmates as "cases". We realise that each one is a human microcosm, with its own characteristics, its own life history, intensely interesting to itself and some small surrounding circle. Very often it is confided to some of us.[310]

Not only this vision, which she, as an evangelical Christian rejoiced to see being put to practice, but also the innovative use of analgesic drugs impressed Cicely when she joined St Luke's team. For the first time in her health service career she saw the dying patients 'with both their mental and physical pain relieved so that they were relatively comfortable, yet alert, almost until the end.'[311] This was achieved by regular giving of pain-killers, before the recurrence of pain. Medication was administered where possible by mouth rather than by injection.

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[309] David Tasma felt he was dying after an unfulfilled life and found comfort in the thought that his death might have a meaning. In one of their conversations he told Cicely: 'I'll be a window in your home': Shirley Du Boulay, *Cicely Saunders: The Founder of the Modern Hospice Movement* (London: Hodder & Stoughton, 2nd rev.ed., 1994), 58 [hereafter abbreviated *CS*].
[310] Ibid, 61.
[311] Ibid.

With cancer taking place of tuberculosis as the most common incurable disease,[312] the numbers of patients in need of specialised terminal care grew rapidly. They were also no longer confined to the lower classes of the society. However, in the medical world the quest to find a cure prevailed over the demands of care. The skills and the knowledge acquired in the hospices for some unaccountable reason were neither systematically studied nor widely spread. Perhaps, the fact that hospices relied mainly on visiting physicians and had no doctors on their staff could have been one explanation.[313] At the time pain in the terminally ill was a totally new field in medicine and having graduated as a doctor Cicely Saunders received a research scholarship from the Halley Stewart Trust to work under the supervision of Professor Harold Stewart at St Mary's Hospital. She spent three days a week at St Joseph's Hospice in Hackney, 'observing the patients, evaluating the use of drugs and, most important of all, listening.'[314] In 1958 St Joseph's had 150 beds in total, between forty and fifty of which were for dying patients, the rest occupied by homeless frail and elderly and those with chronic illnesses who did not qualify for rehabilitation.

> It was outside the National Health Service, but contractual arrangements with the Health Service meant that for most patients it was free. Only three of the nuns were trained nurses, the rest were auxiliaries – young Irish girls. They all worked prodigiously hard, seven days a week with just one two-week holiday a year, nevertheless the nursing care was excellent, the nuns serene and the atmosphere cheerful. Though the medical care was unsophisticated, the patients felt accepted in their pain and anxiety. The nuns were not trained to cope with acute pain, or some of the distressing symptoms that can accompany terminal cancer, such as intractable vomiting or breathlessness; there were no resident doctors, just two part-time GPs, busy with their own practices.[315]

Cicely Saunders was the first doctor to give all her time, skills and versatile professional expertise exclusively to the dying. She applied the regular giving of analgesics, which she has learnt in St Luke's, starting with Omnopon and gradually introducing morphine. This technique was the beginning of a real breakthrough as it has clinically proved not to turn the patients into 'drug-addicts', which has always been and to some extent still remains the dread of the medical profession. Cicely Saunders wrote:

> It is our experience that if pain is kept permanently in remission tolerance is remarkably slow in developing and may never appear. We have patients on the

[312] According to Clare Humphreys tuberculosis remained one of the leading causes of death until the mid-twentieth century: WLS, 156.
[313] Only the Hostel of God had a salaried Medical Officer and St Luke's had a Medical Superintendent: ibid.
[314] *CS*, 69.
[315] Ibid, 69-70.

> same dosage for months and even years, and many who have had drugs on request before they come to us are able to have less analgesic in the twenty-four hours once control has been established.[316]

The other method that she carried on from St Luke's was giving the medication by mouth whenever possible. It helped the patients to retain as much independence as they possibly could.

In the 1960s many new drugs became available and by painstaking investigation Dr Saunders was finding ways of improving symptom control as well as advancing pain control. Having been a nurse herself, she involved the nursing staff in the decision-making process with regard to treatment. Her prescriptions were written in a way that allowed a certain flexibility in the dosage so that the nurses could assess it according to the immediate needs of the patient. The type of drugs, the dosage and the frequency of giving were reviewed on a regular basis. She entered a neglected field and laid the foundations for a new medical specialty. During her time at St Joseph's she produced meticulously detailed records on each of the thousand patients dying of cancer that she observed. The patient's family, if there was one, was included in the notion of each patient being a 'human microcosm'. Equally important, she took the love, which permeated the atmosphere in St Joseph's, and turned it into a new philosophy of care by insisting that 'feelings are facts in this house'.[317] No wonder the nuns at St Joseph's were calling her 'Manna from Heaven'.[318]

The success of Dr Saunders' activity soon reached the wider world. Many visitors to St Joseph's, including nurses, medical students and simply anybody who was interested to learn, were gladly taken round the hospice. Dr Leonard Colebrook, the chair of the Voluntary Euthanasia Society, who visited St Joseph's in 1959, 'was impressed to the point of bewilderment'[319] by what he saw there. Afterwards in his letter to Cicely Saunders he wrote:

> The visit did help me very much to try and get this difficult problem in perspective. I still feel that there would be little or no problem of euthanasia if all the terminal disease folks could end their lives in that atmosphere you have done so much to create – but alas that can hardly be for many a long year and meanwhile, how many thousands will end their lives in very different circumstances? You will raise the standard of terminal care throughout the profession – more power to you.[320]

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[316] *CS*, 71.
[317] Ibid, 72.
[318] Ibid, 71.
[319] Cicely Saunders' expression in her letter to her former tutor Betty Read, quoted in *CS*, 72.
[320] *CAAS*, 283.

Finally it was the time to act. Now Dr Saunders could start building round that 'window' left to her by David Tasma. With the help of many professional and personal friends who shared her new vision for terminal care, she managed to raise money on top of David's five hundred pounds and bought two sites in Lawrie Park Road in London. In March 1965 the first spit for the future building was dug. The new Hospice, named after St Christopher, was officially opened on 24 July 1967 by Princess Alexandra. It was the first modern hospice in the UK and in the world.

3. From St Christopher's World Wide

St Christopher's Hospice was not just another home for the dying. It was a new type of institution based on the central idea of combining 'deeply rooted spirituality with the very best care that medicine can provide.'[321] This idea presupposed not only a particular practice or method, but also a way of life that has developed into the hospice movement, the impact of which 'does not depend on bricks and mortar.'[322] The most significant part of this impact consists in the emerging specialty of palliative care, which was officially recognised in 1987 simultaneously in the UK, Australia and New Zealand.[323] In 1990 the World Health Organisation gave the following definition:

> Palliative care is the active, total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best possible quality of life for patients and their families.[324]

The National Council for Hospice and Specialist Palliative Care Services reaffirmed the lasting relevance of this definition.[325] The range of incurable conditions to which palliative care can be now applied is from cancer to MND and is constantly widening. It includes both malignant and chronic illnesses. Palliative care affirms life, while neither hastening nor postponing death, and can be delivered at home, in nursing homes, within residential care, in hospitals and specialist units.[326] Hospice care comprises specialist palliative care services for those whose death is anticipated. Terminal care is provided

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[321] *CS*, 88.
[322] The phrase used by Sir George Young, Parliamentary Under-Secretary of State, Department of Health and Social Security. Quoted in Cicely Saunders, Dorothy H. Summers and Neville Teller (eds.), *Hospice: The Living Idea* (London: Edward Arnold Ltd., 1981), vii.
[323] *CAAS*, 292.
[324] *Cancer Pain Relief and Palliative Care.* Report of WHO Expert Committee. Technical Report Series 804. Geneva, 1990, 11.
[325] Avril Jackson and Ann Eve (eds.), *Directory 2002: Hospice and Palliative Care Services in the United Kingdom and Republic of Ireland* (London: Hospice Information, 2002), ix.
[326] National Council for Hospice and Specialist Palliative Care Services, *Specialist Palliative Care: A Statement of Definitions* (Occasional Paper 8) (London: NCHSPC, 1995), 52 [hereafter abbreviated NCHSPC].

within the hospice care for patients during their last few days, weeks or months of life.[327] All this has emerged and gradually shaped into a system due to St Christopher's role not only as a model hospice, but also as an excellent clinical research and education facility, much of which stems from the extraordinary personality of its founder, now Dame Cicely Saunders. The largest and best developed in the UK, this system has overtaken the world and is constantly spreading and improving. At present there are 98 countries where palliative care services are already established in various forms and a further four countries are working towards it. The estimated number of services is reaching eight thousand.[328] These include hospices, home care teams, day care centres and hospital palliative care units.

III. The Russian Context

1. Background

One of the patients who died in St Christopher's in the mid-1970s was Jane Zorza, a 25-year-old girl with advanced melanoma. Her parents, Victor and Rosemary, later wrote a book *A Way to Die: Living to the End*, which described how hospice care enabled their daughter to have a peaceful and beautiful death. Published in 1980 and subsequently translated into many languages this personal account changed the way of thinking about dying in many countries and gave strong support to the international force of the growing hospice movement. Victor Zorza, a political journalist born in Western Ukraine, helped to open the first Russian hospice, 'Lachta', in St Petersburg in 1990. The second hospice appeared in Tula in 1992. The building of the First Moscow Hospice was officially opened in 1997. At present there are hospices, hospital palliative care units and pain control departments in more than fifteen Russian regions.

To start establishing itself on Russian soil the idea of hospice care had to overcome three main difficulties.

First of all, the subject of death was in a certain way taboo during Soviet times. For those Russian doctors who realised the needs of the dying patients there was virtually nothing to build on. If Cicely Saunders could draw most of her knowledge and inspiration from a continued tradition of religious institutions for the dying poor, Andrey Gnezdilov, the founder of the first Russian hospice, had to start from scratch

[327] NCHSPC, 53.
[328] Summary of Hospice and Palliative Care Provision by Continent, http://www.hospiceinformation.info/docs/worldwide_stats.doc (21 August 2002).

totally relying on his own intuition and experience as a doctor. Seventy-odd years of communism had on the one hand completely destroyed the social ministry of the Church and on the other hand carried the medical bias towards cure to its utmost. Within the communist ideology of social equality and the quest for a 'happy future' there was no place for the spiritual either in health or in illness. Death acquired a meaning only in the forms which were seen to be heroic: on the battlefield or in social martyrdom. Prolonged dying from an incurable disease seemed to be not only disgraceful, but also devoid of meaning. Since religious beliefs in the afterlife were declared myths, such a death could not quite fit into the pattern of living. Hence it was 'not to exist, not to be seen or encountered.'[329] Soviet medicine was uncompromisingly 'victorious,' and cases that fell short of curative treatment were regarded as defeat.[330] Nonetheless the patients who personified this defeat did not disappear, they still lived and suffered. They spent their last days either in the specialised cancer clinics or at home. The building of the Moscow Oncology Institute named after P.A. Herzen is said to have been designed specifically as a symbol of horror, because cancer was something to be feared, something that had no place in the happiness of the communist society.[331] It is a multi-storey grim construction, whose exterior gives the patient an impression that his condition must be grave indeed, if he is sent to this monster for treatment. Inside is no better: Boris Yudin, psychologist in the First Moscow Hospice, compared the set up in the institute to the production line of a factory, where the patient is transferred from one stage of the process to another without being much considered. It has to be said, though, that only a small number of people actually died in the special institutions. After exhausting the possibilities of curative treatment patients were discharged to bring down the official mortality rates. With the underdevelopment of pain control and the absence of palliative care approach deaths at home were often excruciating and lonely. The end of the communist regime and the spiritual revival that followed made it possible for Russian society to discuss the problem openly and to take on board Western experience in end-of-life care. One of the greatest silences of the Soviet era was vocalised in the birth of the Russian hospice movement.

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[329] The phrase used by Vera Millionshikova, seminar on the needs of terminally ill at the First Moscow Hospice, 25 December 2001, personal recording.

[330] Interview with Vera Millionshikova, Medical Director of the First Moscow Hospice, http://www.hospice.ru/win/intervie.html (22 August 2002).

[331] Everybody who sees the building immediately has that feeling of induced fear. The architect later confirmed to Vera Millionshikova that it was planned to that effect. Seminar on the needs of terminally ill at the First Moscow Hospice, 25 December 2001, personal recording.

However, this acknowledgement was not sufficient. To secure non-interference in the quest for medical victories the system had created a concept of the 'sacred lie', which was so successfully implemented in the mentality of generations of doctors that it is still to be overturned. The patient was never told the true diagnosis if the disease appeared to be malignant. As Professor Boris Peterson, the former Head of the Moscow Oncology Institute named after P.A. Herzen, put it: 'We frequently tell our patients that it is necessary to operate on account of ulcers, benignant neoplasms, etc.'[332] This medical conspiracy was believed to be beneficial for the patient, oriented to mobilise him to fight the disease. It may have worked where the treatment succeeded, but those unfortunate ones for whom it was a failure were left in total psychological as well as social isolation. By the last stages of the illness they would know the truth, in spite of the joint efforts of others to conceal it. This situation maintained the vicious circle. How could one discuss one's death if nobody admitted to the existence of incurable diseases? The home care team of the First Moscow Hospice still comes across families who ask them not to mention that they are from the hospice, but to introduce themselves as social services or as coming from the local polyclinic.[333] However, most of the patients would be well aware of their real condition, but would not have the opportunity to share their knowledge and in doing so ease the burden of suffering. The secrecy that surrounded cancer has also created collateral myths about it being contagious and untreatable. In this situation the ostracism experienced by patients reached its climax.

In 1998 Article 31 of the *Foundations of the Healthcare Law of the Russian Federation* for the first time stated the patient's right to see his medical history and to be provided with the copies in order to get a second opinion.[334] In the past, medical documentation was never shown to the patient. Like criminal records, it had to be always locked away and not to be left unattended. Hospices must have contributed to the legal change, as they work with self-referral. However, several generations being brought up in a totalitarian state, it takes time to realise that one does have rights and to learn how to exercise them. The psychological set-up formed by seventy years of living in fear will take decades to get rid of. Moreover, in an unstable economic situation, where only some can afford commercial medicine and state healthcare keeps itself going on bribes, it is extremely problematic to stand up to the system when faced by a life-threatening illness. Therefore the right to information about one's medical condition

[332] Michael Ryan, 'Ethics and the Patient With Cancer', *BMJ*, 25 August 1979, 480-481.
[333] Vera Millionshikova, seminar on the needs of terminally ill at the First Moscow Hospice, 25 December 2001, personal recording.
[334] *FHL*, 25.

still remains mainly on paper, restricting the patient's ability to participate in the choice of treatment options in the earlier stages of the disease. And the pre-existing superstitious beliefs about cancer, reinforced by the negative aura surrounding it, result in most cases being diagnosed at the third and fourth stages of the disease.

The third stumbling rock inherited from the Soviet healthcare system is 'the continuing negative attitude towards morphine'.[335] It is still largely regarded as highly addictive and inevitably developing tolerance. Although Cicely Saunders by her clinical research in St Joseph's had proved this to be a misconception, which was later reaffirmed by the studies that Dr Robert Twycross carried out in St Christopher's and is constantly reconfirmed by palliative care specialists world wide, the limits on the dosage for terminal pain relief in Russia are still stipulated by the Ministry of Health regulations.[336] Not very long ago the stated maximum daily dosage of narcotic drugs per patient was 50 mg.[337] It has now been increased to 120 mg.[338] It remains incomprehensible how these restrictions manage to co-exist with the WHO guidance on cancer pain control, officially recognised and adopted in Russia for hospice practice, which clearly indicates that there is no upper limit even on the dosage of strong opioids in terminal care.[339] Since all the hospices in Russia are run by the state, this situation, compounded by the general inadequate drug supply, is very difficult to resolve. Palliative care specialists have to be inventive in finding the best combination of the available quantities of opioids and NSAIDs (non-steroid anti-inflammatory drugs) to achieve the needed quality of pain control. Very often, as Dr Andrey Gnezdilov put it, 'clinicians are the real medication for the dying patient'.[340] In other words, in the deficit of analgesics, the doctor has to help the patient by 'offering oneself', concentrate harder on providing psychological support. For almost fifteen years before he was able to open the first Russian hospice 'Lachta' in St Petersburg, Dr Gnezdilov was doing exactly that. In his work as a psychotherapist with cancer patients he pioneered setting up an unusual theatre at home. Patients were invited to an evening performance, where they

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[335] Stuart Milligan, 'Sharing Experiences', *Palliative and Cancer Matters*, Issue 25, June 2002, 5.

[336] Министерство здравоохранения РФ, Приказ № 2 от 09.01.2001 г. (приложение)/Ministry of Health of the Russian Federation, Order No. 2, 9 January 2001, Supplement, http://www.nedug.ru/lib/docum/doc02/min2001_6.shtml.html (26 August 2002).

[337] Андрей Гнездилов, *Путь на Голгофу: очерки работы психотерапевта в онкологической клинике и хосписе* (Санкт-Петербург: АОЗТ «КЛИНТ», 1995)/Andrey V.Gnezdilov, *A Way to Golgotha: Essays on the work of psychotherapist in the oncology clinic and in the hospice* (St. Petersburg: AOZT 'KLINT', 1995), 38 [hereafter abbreviated *WG*].

[338] Pavel Lopanov, Head of Social and Medical Development, the First Moscow Hospice, personal communication.

[339] See, for example: NCHSPC, Working Party on Clinical Guidelines in Palliative Care, *Guidelines for Managing Cancer Pain in Adults* (London: NCHSPC, 1994), 11.

[340] 'Sharing Experiences', 5.

could dress up as different characters and take part in acting. This helped them to communicate their feelings non-verbally and to distance themselves from 'personification of cancer'.[341] This is an account of a visit to this house theatre:

> Andrei greeted us, dressed in top hat, tails and cane. His assistant was also dressed in period costume. Andrei explained this was part of one of the therapies he uses. He showed us a wall covered with dozens of dolls (clients are asked to choose one which they feel represents them, and keep it with them throughout their consultation). His flat was full of objects and artefacts, many of a religious nature, or with some other spiritual significance. Most impressive were the flat metal "bells" which he also uses as part of his therapy. Also of interest were the wire sculptures representing different human emotions and experiences which seem to take on life of their own when they are placed on a revolving turntable and a light used to cast their shadows against the wall.[342]

It is interesting to note that before the experience of his foreign colleagues became known in Russia, Dr Gnezdilov's practice targeted all the three difficulties that cancer patients faced within the Soviet system. In acting the taboo of death was broken, the 'sacred lie' gave place to the openness of non-verbal communication, and the feeling of being accepted made up for the inadequacies of pain control.

2. 'Personified Therapy'

Just like Cicely Saunders, Andrey Gnezdilov converted his long standing personal experience into a way of thinking which shaped the character of Russian hospice philosophy. The principles outlined at the end of his book *A Way to Golgotha,* were later expanded by the team of the First Moscow Hospice to form the Hospice Commandments:[343]

> 1. Hospice is not about death. It is about dignified life till the end. We just work with people whose lives are shorter than ours.
> 2. Hospice is the place to ease pain and suffering, attending both to body and soul. There is little we can do on our own, only together with the patient and family our resources are endless.
> 3. Neither hasten nor impede dying. Everyone has their allotted span and we are only fellow travellers on the way.
> 4. Death and birth are free of charge.
> 5. Absence of cure should not equal absence of care. Tiny things that go unnoticed when healthy are much appreciated when sick.
> 6. The patient and family are a whole. Do not judge, help.
> 7. Approaching the end gives wisdom. Watch out for it...

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[341] *WG*, 89.
[342] 'Sharing Experiences', 6.
[343] Первый Московский хоспис/Что такое 'философия хосписа'?/The First Moscow Hospice/What Is 'Hospice Philosophy'? http://www.hospice.ru/win/philo.html (27 August 2002).

8. Everyone is a personality. Do not impose yourself. You receive more than you can give.
9. Your image is the hospice image.
10. Never rush your visit, sit down. However short the time it is enough to do your best. Caring for the family of someone who has died is part of it.
11. Accept everything from the patient, even aggression. Understanding before action, acceptance before understanding.
12. Tell the truth if the patient feels like hearing it. Always be open, but never push.
13. Whether planned or unexpected, your visit is equally appreciated. Come often, call if you cannot come, think if you cannot call and...lift the receiver.
14. The hospice is a home. Behave accordingly.
15. Being kind, honest and open is not for the patients, it is a way of life.
16. The main thing you should know is that you know very little.

These commandments to a great extent reflect the hospice care philosophy world wide. However, the experience of both the first Russian hospice in St Petersburg and the First Moscow Hospice show that there are differences in practice, which largely stem from the peculiarities of the background outlined in the previous section.

As the first commandment emphasises, hospice is not a place of death, it is first and foremost a place of living. It does not take people to die, it helps them to live with their illness. The idea behind the hospice as a specific building is to provide a short-term support for the patients and their families. The aim is to enable people to stay at home as long as possible and to admit them only to work out or adjust an individual pain control scheme, or to provide respite care where needed. However, two-thirds of the hospice patients in Russia actually end their lives there. As Gnezdilov remarks, this is a 'bad figure',[344] which gives a wrong impression about the tasks and aims of hospice as an institution and runs contrary to the philosophy of it.

A complex of cultural, social and economic reasons accounts for this 'unfortunate' statistic. The Soviet perseverance in banning death from the socio-cultural context backfired after the ban was lifted. Paradoxically the hospice movement in the post-communist Russia while struggling to destroy the former ideology is trapped in the consequences of it. Death having been shut off for so long a time resulted in the inability of people to face it[345] and hospices rather than helping to re-establish the long-forgotten practice of caring for the dying at home, within the family circle, adopt the role of a modern substitute of this tradition. The fact that all Russian hospices are state-

[344] *WG*, 49.
[345] In autumn of 2001 Andrey Gnezdilov opened his address at the first International Conference of the Multinational Centre for Quality of Life Research by stating that 'Russians can't cope with dying': 'Sharing Experiences', 5.

run[346] creates an impression that death, once reinstated into the public agenda, has been immediately institutionalised. There was a lot of misunderstanding and poor communication before a satisfactory interaction between local polyclinics and hospices was established. Until then self-referral dominated, which more often than not took place when there was too little time left for proper terminal care and people died in the arms of the hospice team.[347]

On the one hand, after the decades of cultivating the ideology of death as a 'no man's land', when there was no place for dying within the healthcare system, hospices came as a proper *locus*, that long-awaited missing structure into which it might fit. In other words, the figure over which Dr Gnezdilov laments will remain the same as long as the hospice is perceived to be a place of death. Moreover, this distorted perception is unwittingly strengthened by the absence of any kind of life-support machines in the Russian hospices,[348] which is often presented as an integral part of the hospice philosophy, which it is not. For example, in St Luke's Hospice in Kenton Grange in London they do have ventilators and even resuscitation equipment.[349] Artificial ventilation is part of the everyday life for some of the children at the Rainbow Family Trust in Manchester.[350] It is not that the use of medical technology ends where hospice care starts; they just do not need to be mutually exclusive. The aim of hospice philosophy is not the rejection of modern biomedical achievements, but the balanced and appropriate use of them. As Dame Cicely Saunders' vision goes, 'a hospice as a protest against the shortcomings of modern high technology' should not 'lose the benefits that modern technology has to offer.'[351]

On the other hand, family bonds in Russia are traditionally very strong and even after seventy-odd years of brainwashing most people appear reluctant to put their nearest and dearest in an institution unless it is absolutely unavoidable. If in the West balancing one's own interests and those of others is part of the culture, the Russian mentality is still more of a sacrificial character. Therefore more often than not the hospice is contacted when all the domestic resources, both physical and emotional, are

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[346] 80% of the First Moscow Hospice budget comes from the Moscow city government, the rest is covered by charitable donations: Vera Millionshikova, seminar on the needs of terminally ill at the First Moscow Hospice, 25 December 2001, personal recording. However, the inpatient unit of the Lomintsevsky Hospice in Tula is financed chiefly by an American organization (but still run by the state).
[347] Report by Dr T.V. Saveljeva, consultation on palliative care in the First Moscow Hospice in 1994 (unpublished materials).
[348] My interview with Pavel Lopanov (28 December 2001).
[349] My interview with John Corner, Chairman of St Luke's Hospice, Kenton Grange, London (18 July 2002).
[350] My interview with Margaret Hickie (17 June 2002).
[351] *CS*, 183.

not just at a low ebb, but completely exhausted. In such circumstances it is difficult to see the hospice as 'a home from home' and not as a grim and hostile 'point of no return'. Instead of offering respite care, Russian hospices end up being 'a last resort'.

If some families succeed in their struggle to look after the sick person till the end, for those lonely souls who do not have any relations the hospice becomes a place to end their lives simply because there is no other. In the situation where the system of social services is appallingly weak, many of those who are admitted to the hospices on the basis of so called 'social indications' end up spending months and even years there.[352] Ailish Carr, Ward Manager at St Christopher's Hospice in London, where the average stay is not more than several weeks, during her visit to one of the Russian hospices was puzzled to find patients who had been there for several months.[353] Compared to Britain, where hospice provision complements the services available within the web of residential care, nursing homes and a wide range of specialised charitable organisations, Russian hospices often have to act as a substitute for them. Again, instead of exemplifying a new approach to the life affected by a serious illness, they appear as just another type of institution for the dying poor.

These cultural and social dimensions are reinforced by economic factors. State disability benefits and pensions can hardly cover basic everyday necessities and make it impossible to stay at home when the illness enters an advanced stage, increasing not only physical and moral, but also financial burdens. Special equipment giving the opportunity to maintain independence and various devices enabling a sick person to remain at home till the end are costly and thus unaffordable for many.

Another distinctive characteristic of the Russian hospice reality is the level of personal emotional involvement required from the staff, which due to the specifics of the Russian situation has a higher toll on them compared to their British colleagues. 'Personified therapy' or 'therapy of presence'[354] are not simply part of the concept of 'total care' integral to the hospice philosophy everywhere, but the core of the Russian hospice set up. The significance given here to the 'soul to soul' communication between the patient and the carer has led British nurses to acknowledge that a special

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[352] The fact that in Russian hospices many of the patients are admitted for the duration of their illness has been observed by many specialists from abroad. See, for example: Mary A. Cooke, 'The Russian Way of Hospice', *The American Journal of Hospice & Palliative Care*, 7-8 (1995), 9-13.

[353] Ailish Carr, Ward Manager at St Christopher's Hospice in London, personal communication (16 July 2002).

[354] Terms coined by Dr Gnezdilov. See: *WG*, 49; А.В. Гнездилов, 'Психотерапевтические аспекты в хосписной службе', *Паллиативная Медицина и Реабилитация*, 1 (1998), 31/ A.V. Gnezdilov, 'Psychotherapeutic Aspects of the Hospice Services', *Palliative Medicine and Rehabilitation*, 1 (1998), 30.

expertise of easing the suffering as opposed to the art of pain relief undoubtedly belongs to their Russian colleagues.[355] This, of course, reflects first and foremost the nature of the society in general. In Britain the high quality of life in terms of material wealth, social security and legal awareness of the citizens naturally extends to the hospice environment. In post-Soviet Russia, the impact of political turmoil and economic instability compounded by legal ignorance and the seriously underdeveloped network of community-based services becomes fully exposed within the hospice system. This general connection between the aspects of societal reality and the needs of the hospice patients is an important part of a cultural set-up within which palliative care specialists inevitably find themselves. However this connection can be interpreted in different ways. Some would argue, as Andrey Gnezdilov does,[356] that the high level of personal engagement on the part of the staff in the Russian hospices is determined and sustained by the deficit of medications and the unwise restrictions on narcotic painkillers applied by the Ministry of Health. Others, like Vera Millionshikova, Medical Director of the First Moscow Hospice, have a deeper insight into the matter and are certain that the psychological make-up consequential to the totalitarian regime will take a long time to shrug off, the amount or variety of drugs as well as the availability of the most updated medical techniques and special equipment notwithstanding.[357] Dr Millionshikova asserts that 80% of the pain experienced by the patients in Russia is not physical, but psychological.[358] Profound disregard for the person demonstrated by the Soviet state is echoed in the story of every patient suffering not so much, if at all, from pain and discomfort, as from the lack of basic human attention. The psychological component of 'total pain' prevails in the Russian hospices increasing the demand for a healing individual commitment of the staff.

On the administrative side, the biggest problem encountered in the Russian hospices is a rapid staff turnover. The concept of 'burn-out' that has been successfully dealt with in the British hospice system still seriously affects the work here. The 'shelf-life' of approximately three years appears to be rather a norm than an exception for those working in the field of palliative care in Russia. It can be explained by the scope and intensity of the 'therapy of presence', although this alone would not suffice. As the British and, indeed, Western experience shows, whatever the level and nature of

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[355] *WG*, 11.
[356] Ibid, 49.
[357] Vera Millionshikova, 'Peculiarities of the Russian Hospices', a paper delivered at one of the consultations on palliative care in the First Moscow Hospice in 1994 (unpublished materials).
[358] Vera Millionshikova, seminar on the needs of terminally ill at the First Moscow Hospice, 25 December 2001, personal recording.

difficulties involved in the hospice work they need not trigger professional 'expiry dates'. They need to be balanced by an appropriate staff support, which includes 'issues of recruitment, orientation, training, appraisal, communication and team-building'.[359] In Russia, however, effective realisation of this task is hindered by locating the hospices within the state health care system. For hospice staff salaries, already ridiculously low in Russian healthcare, cannot by definition be compensated by 'side earnings'. Thus permanent staff see their work as a vocation rather than professionally enhancing or career beneficial. Even more so is it for volunteers, who are significantly smaller in numbers compared to their Western counterparts.

Instead of moving 'out of the National Health Service in order that ideas and knowledge could move back in',[360] which task has been successfully accomplished by the hospice movement in Britain,[361] the Russian hospices attempt, as it were, building from inside the system. The result is ambivalent. While having introduced certain attitudes and skills previously unknown in the Soviet medicine, the hospices at the same time automatically inherited a heavy negative residue of the old healthcare system. Unfortunately, a lot of time and effort is still spent attempting to shake off the latter leaving much fewer resources to develop the former.

IV. How Hospice Philosophy is Different From Euthanasia

It is repeatedly stressed in the multitude of publications that 'hospice care and euthanasia are mutually exclusive philosophies'.[362] However, in spite of continuous utterance of this mantra, the claims persist that euthanasia and physician-assisted suicide should form a logical extension of terminal care or even that they already exist as part of hospice practice that just fails to be fully recognised.[363] In the face of such disagreements, it is important to understand how proper end of life care should be distinguished from euthanasia.

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[359] Barbara Monroe, 'The Cost to the Professional Carer' in Cicely Saunders and Nigel Sykes (eds.), *The Management of Terminal Malignant Disease* (London: Edward Arnold, 3rd ed., 1993), 236 [hereafter abbreviated *MTMD*].

[360] Cicely Saunders' explanation why she did not want St Christopher's to be part of NHS.

[361] There is a possibility though that since palliative care, as an official specialty, is now a responsibility of statutory bodies (NHS), the core hospice service might end up being funded by the state healthcare system. However, it is extremely unlikely that things will get completely assimilated into it.

[362] Robert G. Twycross, 'Where There Is Hope, There Is Life: A View From the Hospice' in *EE*, 152.

[363] See, for example, how Barbara J. Logue argues this in her article entitled 'Rejoinder to Saunders', *OMEGA*, 32 (1) (1995-96), 7-9.

1. Medical Aspects

With the advances in palliative medicine it became easier to draw the distinction medically, i.e. to determine with the help of clinical evidence whether a doctor intends the death of a patient.

In the use of drugs, the nature of the substance, its quantity and the manner of administration matter. In cases, like that of Dr Cox, the occurrence of euthanasia can be quite easily established on the basis of medical evidence. Injecting potassium chloride, which has no analgesic properties, neat into a vein in quantities double that of the lethal dose has clearly nothing to do with palliative care.[364] With narcotics and sedatives, which are widely used in palliation, this line of demarcation appears to be significantly blurred: the nature of these substances is ambivalent, as they can both relieve suffering and kill. Therefore one should pay more attention to the quantity and to the way of administration. The most comprehensive guidance is summarised by Lo and Jonsen in their concept of a counterfactual test:

> ... a practical application of the test would require the physician to first consider other means of relieving the neurologic symptoms or to try low doses of narcotics and sedatives. If the lower doses were ineffective, he could then give progressively higher doses. Ultimately he might find that the only way to relieve the symptoms would be to make the patient unconscious. But even then the physician would not be justified in giving more than the appropriate dose to maintain unconsciousness. Giving more than this dose would again be intending to kill the patient, and hence be indistinguishable from administering an air bubble or from any other form of active euthanasia.[365]

But how low is 'low' or how high is 'high'? To use this test correctly, it is important to understand that these qualifications do not have a categorical, but a relative meaning. What is decisive is not the physical quantity of the drug given, but its correlation with the patient's medical condition. For some a single dose of 20 mg of morphine can turn out to be lethal, whereas for others 1000 mg is a daily amount which helps them to maintain an active style of life. [366] Palliative care is precisely about the medical skill in striking the balance.[367]

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[364] For a detailed medical expertise in the case see: R v Cox (1992), 12 *Butterworths Medico-Legal Reports* (*BMLR*).

[365] B. Lo and A.R. Jonsen, 'Ethical Decisions in the Care of a Patient Terminally Ill With Metastatic Cancer', *Annals of Internal Medicine*, 92 (1) (1980), 109.

[366] One lady was driving a car on 1g of morphine per day and the cause of her death was something other than cancer (my interview with Margaret Jefferson, St. Cuthbert's Hospice, 6 September 2002).

[367] The standard technique in pain relief, which in most cases also applies to symptom control consists in giving medication 'by mouth, by the clock and by the analgesic ladder': World Health Organisation, *Cancer Pain Relief With a Guide to Opioid Availability* (Geneva: WHO, 2nd ed., 1996).

The same skill is applied when deciding on withholding and withdrawing of treatments or machines. Within the hospice set up it is again, a medical indications policy. Any particular treatment or device has its medical potential. The higher it is, the closer one would be to committing euthanasia in not starting or stopping them. The lower it is, the greater is the likelihood of adhering to good medical practice in abandoning them. Like the dosage of medication, this potential does not have an independent value scale, but corresponds to the patient's medical condition. To refer to the cases in the previous chapter, refusal by the hospice to switch off the artificial ventilation for Miss B would have had perfectly sound medical grounds. In her case, the potential of the device used was high, because it sustained her life. The nature of the disease was such that it would not have precluded her living as long as she will, provided the artificial ventilation was in place. In contrast, for Diane Pretty, the same device would have had its potential at the lowest, if not on zero. The nature of her disease was such that it would not have allowed her to live either way: whether with the artificial ventilation or without it. In her case, it would not have sustained life, but only impeded dying. There are, of course, middle way situations, where in one and the same patient the medical condition varies through the course of their illness, so that greater medical skill is required in adjusting the potential of certain treatments and devices to each particular stage. One example can be determining the time spans during which a patient with a specific illness should be put on and off a ventilator.[368]

2. Christian Aspects

No matter how advanced the science of palliative care becomes, there will always remain 'grey areas', where medical criteria alone would be insufficient to divorce it from the practice of euthanasia. Consider an anonymous account, which appeared under the title 'It's Over, Debbie' in the *Journal of the American Medical Association*:

> I grabbed the chart from the nurses' station on my way to the patient's room, and the nurse gave me some hurried details: a 20-year-old girl named Debbie was dying of ovarian cancer. ... As I approached the room I could hear loud, labored breathing. ... She was receiving nasal oxygen, had an IV, and was sitting in bed suffering from what was obviously severe air hunger. ... A second woman, also dark-haired but of middle age, stood at her right, holding her hand. ... The room seemed filled with the patient's desperate effort to survive. ... She

[368] My interview with Margaret Hickie, Senior Nurse at the Rainbow Family Trust, Manchester, 17 June 2002.

> had not eaten or slept in two days. She had not responded to chemotherapy and was being given supportive care only. ... Her only words to me were, "Let's get this over with."
> I retreated with my thoughts to the nurses' station. The patient was tired and needed rest. I could not give her health, but I could give her rest. I asked the nurse to draw 20 mg of morphine sulfate into a syringe. Enough, I thought, to do the job. I took syringe into the room and told the two women I was going to give Debbie something that would let her rest and to say good-bye.
> ... I injected the morphine intravenously and watched to see if my calculations on its effects would be correct. Within seconds her breathing slowed to a normal rate, her eyes closed, and her features softened as she seemed restful at last. The older woman stroked the hair of the now-sleeping patient. I waited for the inevitable next effect of depressing the respiratory drive. With clocklike certainty, within four minutes the breathing rate slowed even more, then became irregular, then ceased. The dark-haired woman stood erect and seemed relieved. It's over, Debbie.[369]

From a purely medical point of view, there is nothing in this story to indicate that what the doctor had done constitutes euthanasia and not good medical practice. He saw a young woman in what seemed to have been an absolute agony. Since it was not a hospice or a palliative care unit and the doctor was not a specialist in palliative care, but simply happened to be on duty in a large private hospital,[370] he acted to the best of his medical abilities. Opioids, of which morphine is one, are widely used 'for subjective relief of dyspnoea'.[371] Understanding that the only thing he could do for this patient is to give her rest, the doctor assessed the dose, which in his view should have been adequate for this purpose. Neither what has been done nor what has been said suggests the intention to kill – apart from the doctor's acknowledgement that he waited for the patient to stop breathing. This tiny detail recasts the whole story. It speaks of the doctor's calculations in choosing a dose beyond the limit indicated by Lo and Jonsen. The patient was not just rendered unconscious, her breathing was stopped. Yet, if it were not for the doctor's own account, there would have been no grounds for suspecting malpractice. It is a vivid example of the 'razor's edge'[372] situation, where 'the line to be drawn between a primary purpose to alleviate pain, which may, or even will, incidentally cause death, and, on the other hand, a purpose to kill which may – for however short a time – incidentally alleviate suffering'[373] is almost undetectable. It shows that intention, being a difficult philosophical concept, depends ultimately on

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[369] Reprinted by permission in Michael M. Uhlmann (ed.), *Last Rights? Assisted Suicide and Euthanasia Debated* (Grand Rapids, Mi.: Eerdmans, 1998), 317-318.
[370] I am referring to the circumstances, which are omitted in my abridged quotation. They are not essential, but have only an assisting function in the argument that follows.
[371] Louis Heyse-Moore, 'Respiratory Symptoms', in *MTMD*, 82.
[372] The metaphor used by Dr Dixon during the trial and quoted by the judge in R v Cox (1992), 12 *BMLR*, 48.
[373] Submission of the defence, ibid.

what one thinks, not on what one does or says. The latter two can either help or hinder the detection, as words and actions can be interpreted the way one chooses.[374] It is especially true in medicine, where the force of factual evidence is in many cases far from being straightforward. For if there were ways to argue the intention to alleviate suffering in the use of potassium chloride,[375] which does not have any analgesic properties, how much more easier (and persuasive) would it be to do the same where such a well known palliative drug as morphine is used. It seems that the story told in the *JAMA* is anonymous precisely because it holds the doctor's confession, which alone discloses his real intention. Instead of giving the patient rest, he, so to say, laid her to rest. It was her life in the first place that the doctor intended to 'get over with'. The motive, to relieve suffering, however benevolent, does not change the intention.

The above story shows once again, that in the treatment of terminally ill patients a lot, if not all, depends on a doctor's disposition. Engelhardt rightly observes that 'what is important is often not what one does or does not do medically, but why and how one does it'.[376] Hospice is not different from euthanasia in the sense that it is just a different medical practice or even a different philosophy, although it is both. It is at loggerheads with the 'euthanasiac' ethos because it comprises a different kind of people, ones who act out of the Christian commandment 'do not kill'. Everything else within a hospice set up, including medical skills in symptom control, is subordinate to 'hitting the mark' – obeying this commandment. It is not that in the hospice they do not kill because they can alleviate suffering, but they alleviate suffering, because they may not kill. This is the order of priorities, which should be restored in the exchange of arguments between the advocates of euthanasia and those who take a firm stance against it and in favour of the hospice movement. In euthanasia the issue is 'may I kill if ...', in the hospice the issue is 'what if I may not kill'. These two approaches are not only incompatible, they are epistemologically and ontologically opposite: the second strives to fulfill the moral law, while the first seeks to justify the exceptions. This is a core difference and it is not medical or philosophical, but spiritual. The point is that there will always remain a constant per cent, however small, of the cases, which would test to the utmost the steadfast commitment of the hospice staff not to take human life. Such instances would require 'just going with the suffering' and that is hard to do without faith. As Cicely

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[374] Consider Dr Moor, whose arrest and acquittal both depended almost solely on his own contradictory statements. Paraphrasing Keown, only an unusually honest or an unusually stupid doctor would report intention and thereby expose himself to the charge of murder if he has an opportunity to declare foresight of virtual certainty and be acquitted as following 'good medical practice'.

[375] Submission of the defence in R v Cox (1992), 12 *BMLR*, 48.

[376] *FCB*, 319.

Saunders says: 'Only a God whose love shares all pain from within can still our doubts and questions, not because we understand but because we can trust'.[377] Palliative medicine is not the source, but the product of such trust. Therefore Christianity is of crucial importance to the identity of the hospice movement. Christian faith permeates the history of the care of the dying from the early days of AD to the first Hospice for the Dying founded by the Irish Sisters of Charity in Dublin in the nineteenth century. As a result of an inspiration by the religious atmosphere at St Joseph's and in gratitude for a personal conversion, the modern hospice movement took shape in St Christopher's being 'fully committed to the belief that, in Jesus of Nazareth, God knew a human life and the ultimate weakness of death as we know them, and this for all men, whether or not they believe'.[378] The majority of those who work at St Christopher's and in many other hospices throughout the world show unceasing faithfulness to this commitment.[379] Without it no amount of external safeguards can secure the moral integrity of the medical profession. Neither most detailed and tight regulations on issuing death certificates, nor controlling the circulation and limiting the dosage of narcotic drugs in palliative care would alone guarantee us from doctors like Shipman.

V. Conclusion: How Christian Ethics Became Hospice Philosophy

The rise of the hospice movement has fulfilled Ramsey's longing for the day 'when the dominant secular viewpoints on morality will be extended from the church of Jesus Christ'.[380] In the hospice the covenants of 'life with life' are kept by communicating to each and every person: 'You matter because you are you and you matter to the last moment of your life and we will do all we can not only to help you die peacefully but to live until you die.'[381] Being prepared to stay and watch with those who suffer even when there is nothing one can do to ease the suffering is precisely what Hauerwas has always taught is a true Christian bioethics. The hospice has a character that would be immediately recognised by Engelhardt as explicitly libertarian, because it can compass divergent moral visions, while assisting the traditional Christians in the 'final turn from oneself to God, from pride to holiness.'[382]

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[377] *CS*, 158.
[378] Ibid, 158.
[379] Ibid, 165. On the Russian side, Dr Gnezdilov confirms the important role of faith in the hospice work by admitting that 'believers just about compensate for the rapid staff turnover': *WG*, 49.
[380] Quoted in *WW*, 129-130.
[381] Quoted by Cicely Saunders in *CAAS*, 291.
[382] *FCB*, 323.

The growth and development of the modern hospice movement coincided in time with the growth and development of Christian bioethics as an academic discipline. This parallel time scale incurs some analogies in essence. Christian theological thought struggled to clarify its premises on the matter of death and dying by placing its opposition to euthanasia consecutively within Ramsey's concept of covenant, Hauerwas' sobering vision of 'suffering presence' and Engelhardt's uncompromising 'pursuit of the Kingdom of Heaven.' It was a process of wrestling Christian ethics back from its secularised medical version. The academic world gradually came to realise that for opposition to euthanasia to have force it must be explicitly Christian. In contrast, the modern hospice movement started with candid Christianity, but in the second half of the twentieth century what was once a Christian ethics of 'only caring for the dying' has been transformed into a global phenomenon of 'hospice philosophy'. The departure of the hospice movement from its Christian roots is more and more evident nowadays. If St Christopher's was established as a Christian foundation, where everything from the symbol at the entrance to the everyday prayers in the wards witnessed to a religious faith, most of the modern hospices are increasingly non-religious.[383] And this is a worrisome tendency. Without the cornerstone of faith all that the hospice movement has achieved so far can be too easily turned into pre-euthanasia care. A former hospice nurse assisting the patient's suicide in the Swiss organisation 'Dignitas' is just one example. Moreover, if one is to believe authors like Barbara Logue, some hospice staff already accede to the patients' request for euthanasia and 'more would be willing to do so if laws were changed to permit it.'[384] To resist the ever-growing pressures of the liberal ethos the hospice movement has to focus on nurturing its Christian identity, which task seems to have been somewhat neglected in the effort to excel medically.

Conclusion

The above research has highlighted three basic dimensions to the problem of euthanasia, which, understood within a proper scale of importance, are crucial in forming a Christian attitude towards it. Euthanasia as a phenomenon touches upon three main spheres of human existence: legal, moral and spiritual. The intense debate it has provoked over the last decades for the most part concentrated on the legal and moral

[383] When I visited the Nightingale House Hospice in Wrexham, I was told that the chapel is arranged in a way that would provide for the absence of any reminder of a particular religious identity, since the hospice is a non-religious enterprise.
[384] 'Rejoinder to Saunders', 8.

issues, hardly ever ascending to the spiritual level. Within a framework of faith, however, the problem of euthanasia has first of all a spiritual nature.

The meaning currently ascribed to the word euthanasia has caused a lot of controversy and confusion. Both the advocates and the opponents have gone so far in striving to argue their cases that it is now difficult to see the forest for the trees. There are all manner of explanations from both sides as to why euthanasia is a good or an evil, but much less attention to its essence. Euthanasia is neither about mercy, nor dignity, nor personal autonomy, nor best interests. It is primarily about intending death. Being an extremely hard to grasp philosophical concept, intention poses two major problems bearing on the whole of the euthanasia debate.

First comes the difficulty of defining intention. It can be (and indeed very often is) easily conflated with motives, wishes, hopes and desires. To avoid the confusion, one must remember that 'the issue is not *why* the physician performs his actions (for example, for benevolent or malicious motives), but *what* he wants to bring about'.[385] The will to achieve a particular purpose is the core characteristic which helps to draw another important distinction: between intention and foresight. The difference is best argued by John Keown, who asserts that '*aiming* to bring about a consequence is not the same as simple *awareness* that it may or will occur'.[386]

The practice shows that these nuances of definition can effectively impede detection. Human nature being what it is, in deciding about life and death people are more inclined both consciously and unconsciously to camouflage their real intentions. Therefore, although in most cases there is, as Keown points out, the evidence of what they say and/or do, it often turns out to be disturbingly controversial (the cases of Drs Moore and Shipman giving good examples). Words and actions can be skillfully interpreted to the effect one chooses. The danger of manipulation is there in the majority of every day legal cases where juries demonstrate apparent success in spotting intentions. In the medical context the force of the factual evidence is often so inadequate that it only accelerates this danger.[387]

Ultimately then, intention depends on the inner state of the agent. Euthanasia is not so much about how people behave, as it is about who they are. The mistake of secular bioethical frameworks is precisely in their attempt to set up a web of external moral rules to be followed by morally unidentifiable agents. No matter how logically coherent, rules cannot properly function unless sustained by those who know where

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[385] 'Ethical Decisions in the Care of a Patient Terminally Ill With Metastatic Cancer', 109.
[386] *EEPP*, 18.
[387] See J Ognall commenting on this in R v Cox (1992), 12 *BMLR*, 40-41.

they come from. The prohibition of killing which was once meaningful no longer holds water precisely because it has lost its moral agency and became purely legalistic. It is the value and the advantage of Christian bioethics that it starts by identifying the kind of people to address the rules to. With Paul Ramsey these are people of the covenant. With Fletcher these are people of love. Paradoxically, however, in the history of Western Christian bioethics these and similar concepts have led to the justification of killing in certain circumstances. Not least, it seems, because it has long been forgotten what it really takes to be people of the covenant, to live in a true Christian love and to exercise faithful stewardship. Stanley Hauerwas came as a reminder. His was the call for Christian bioethics to be lived and, thankfully, it sounded no less challenging and up to the moment than Peter Singer's urge to 'rewrite the commandments'.[388] Tristram Engelhardt actually reintroduced the Christian meaning of covenant, love and stewardship within the endless journey to holiness. The ethics of asceticism shows that many Christian intellectual anti-euthanasia undertakings have gone astray because 'when the heart is clouded, discursive reason tends to start from the wrong premises and therefore fails to provide the kind of conclusions to which natural law philosophers aspire'.[389] Starting with Ramsey, Christian bioethicists in the West have continuously stumbled over the problem of justification. Sensing that no matter how hard they try there would still exist the killings one cannot avoid, they began simply to claim them exempt from the prohibition of the sixth commandment and thus morally justifiable. No wonder such an approach at best rendered Christian bioethics indistinguishable from the secular one, at worst created an impression of sheer hypocrisy. Hauerwas was the first to understand that theodicies should be exchanged for the living experience, but concentrated more on the form rather than the substance of it. He vigorously insisted that as Christians we should learn to live with evil, not eliminate or explain it. And Engelhardt's therapeutic approach shows how it should be done. The focus is not on justifying certain forms of intentional killing while condemning others, but on purifying one's heart and cultivating one's soul in a way that would not allow evil intentions to form. To be of effect this spiritual labour should start with attention to the foresights of evil of various degree of certainty. Not only intentional killing as a voluntary sin harms the soul gravely and requires the most serious therapy of repentance, but also unwilling

[388] Peter Singer, though undoubtedly a prominent figure in the world of modern bioethics, in his works takes the stance, which, to my mind, is not only post-Christian, but indeed anti-Christian.
[389] From a recent unpublished interview given by Tristram Engelhardt, Jr. to Mihail Neamtu from King's College, London. Courtesy of the interviewer.

homicide as an involuntary sin can cause a spiritual injury which, if left untreated, will eventually add up to form a deadly intention.

Before asking whether euthanasia should become part of our lives we should ask ourselves what has happened to us that prompted such a question. The real issue is not whether euthanasia is a curse or a blessing for the society, but what is the driving force behind it. Within the liberal framework euthanasia is gradually beginning to be seen as an ultimate cure not only for a physical illness, but also for suffering in general. This kind of reasoning can be appealing indeed if taken within the boundaries of this earthly life. However, from a truly Christian point of view it is nothing but an upside down spiritual logic. As Christians, we place the meaning of our existence beyond the individual life span in eternity and therefore in preparation for it view suffering as a cure for various spiritual illnesses of which euthanasia is one. This is a core difference in mentality that should be observed if we are to resist the spiritually awesome force of global euthanazation.

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